Patient Name: ______________________ Appt. Date:__________

Date of Birth: ______________________ Appt. Time: _________

(Appointments can be made by the dentist's office or by patients)

*** Next appointment date with referring doctor: ______________

<u>Note to Patients</u> - Payment is due when services are rendered. We do not accept assignment of dental insurance. Please bring this referral slip with you.

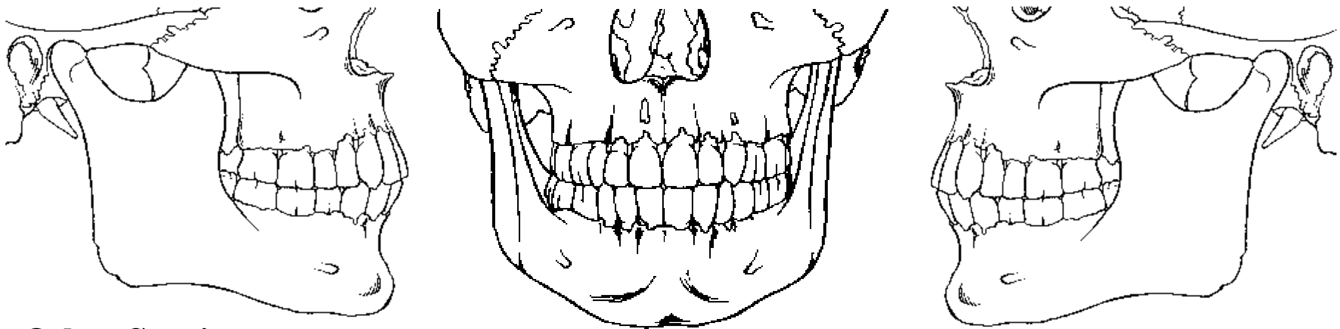
3-D CBCT Volumetric Imaging ($400)

This service includes one CBCT imaging session, an oral radiological consultative report and a printed set of reformatted images. *(Standard turnaround time for delivery of reports is 4-5 business days after the date of scan. Please call our office to make special arrangements for RUSH scans).*

☐ Implants ☐ Dental Impaction ☐ Airway assessment ☐ Sinus exam

☐ TMJ exam ☐ Oral Pathology ☐ Endodontics ☐ Other ___________

Please <u>circle</u> the Region of Interest (ROI)



Other Services

☐ Orthodontic Records ($260) (Digital photos, volume views of skull and dentition, panoramic x-ray, lateral ceph with digital tracing)

__ Initial __ Progress __ Final Preferred Analysis: ______________________________

(if no analysis is indicated, the standard Steiner Analysis will be provided)

☐ Additional printed reports ($25 per report)

Total Amount Due: ________________

Special instructions: ____

____

____

By signing below, I request Advanced Dental Imaging and its associates to acquire, review and interpret the images and have obtained authorization from the patient for these procedures.

Dr. (Print Name) : ______________________________ Date:___________________________

Signature: ______________________________

Advanced Dental Imaging, 1945 Village Center Drive, Suite 150, Las Vegas, NV, 89134

Tel: (702) 212-9111 **Web : www.advanceddentalimaging.com**

Fax: (800) 635-4282 **Email: info@advanceddentalimaging.com**

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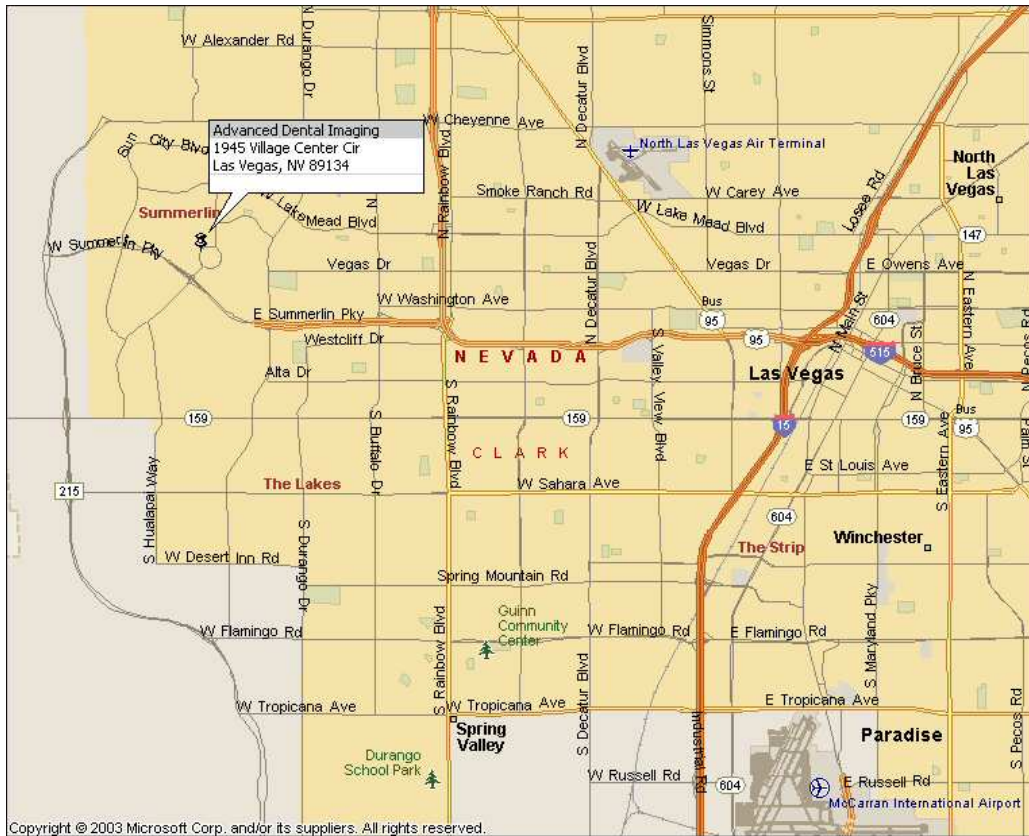

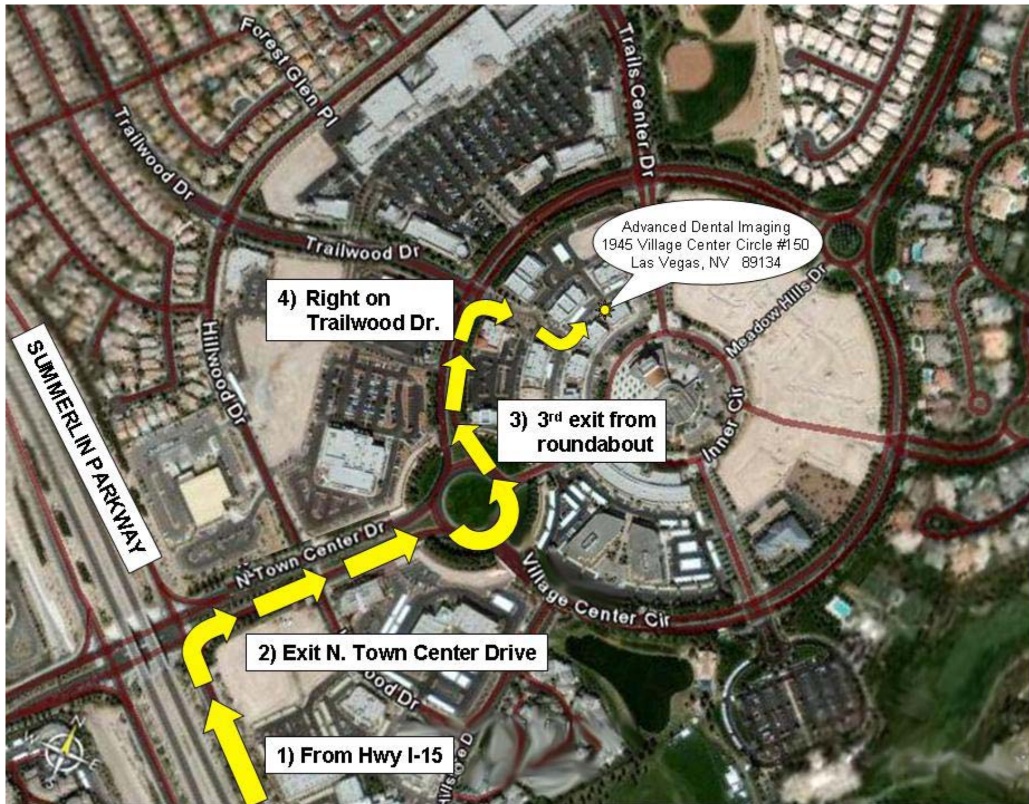

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