



**Advanced Digital Imaging
for Dentistry**

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: _____

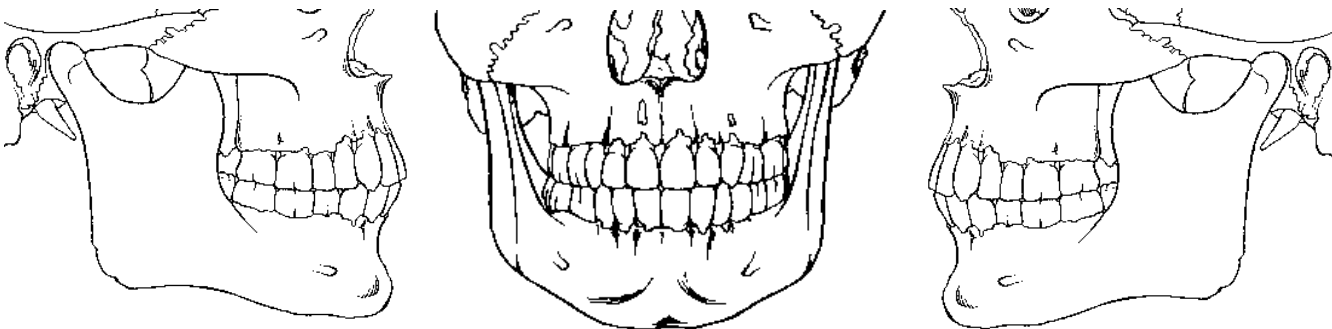
Note to Patients - Payment is due when services are rendered. We do not accept assignment of dental insurance. Please bring this referral slip with you.

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 circle the Region of Interest (ROI)



Other Services

- Orthodontic Records (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 Digital Imaging for Dentistry 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 Digital Imaging for Dentistry, 73-733 Fred Waring Dr., Suite 208, Palm Desert, CA, 92260
Tel: (760) 423-0808 Web : www.advanceddentalimaging.com
Fax: (760) 423-0818 Email: info@advanceddentalimaging.com

**Prescription is valid until December, 31, 2008.
Please check our website for updated prescription forms**

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