

PATIENT REFERRAL FORM

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Email: Susan@advanceddentalimages.com

Patient name: _____

Date of birth: _____

Contact phone number: (____) _____

Appointment date: _____ time: _____

Services:

ICAT 3D Scan (includes a CD of DICOMM data and ICAT vision software)

Send to 360 Imaging for Radiology report Surgical guides

Reason for scan:

IMPLANT SITE _____

TMJ OPEN CLOSED

ORTHODONTICS

ORAL SURGERY

PATHOLOGY

TRAUMA

ENDO

AIRWAY ASSESSMENT

SINUS EVALUATION

Other _____

Image modeling software

Nobel

Simplant

Dolphin

Keystone

Implant Logic

Facilitate

Ident

IMPLANT TYPE

IMPLANT SITES

NOTES:

PLEASE BRING YOUR **MEDICAL** INSURANCE CARD WITH YOU

Referring Doctor:

Print name: _____

Signature : _____