dsc
the dental scan center
www.thedentalscancenter.com

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Patient Information

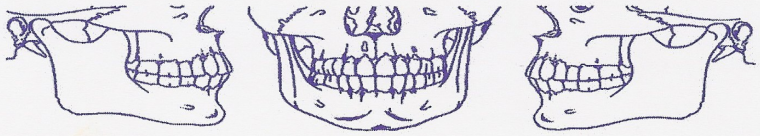
Patient Name:_____ DOB:_____/_____/_____

Address: _____

City:_____ State:_____ Zip:_____

Home:_____ Cell:_____ Email:_____

Please circle the Region of Interest (ROI)



Implants:

Implant area: Mandible_____ Maxilla_____ Both _____

Scans of both jaws are recommended for optimal implant planning, occlusal analysis, and determining correct emergence profile for the implants.

Is your patient coming with a radiographic template? Yes ❑ No ❑

(Indicate teeth or area of interest)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

REASON(S) FOR CONE BEAM CT REFERRAL:

Pre-surgical planning:

☐ Implant planning ☐ Open ☐ Closed
☐ Sinus assessment ☐ Inferior alveolar nerve tracing/assessment ☐ Mental nerve tracing/ assessment ☐ Third molar assessment
☐ Anatomy or tooth morphology assessment
☐ Periodontal surgery ☐ Endodontic surgery

Other assessments:

☐ Oral pathology assessment ☐ Airway/sinus assessment ☐ Sleep apnea study ☐ TMJ assessment: ☐ Open ☐ Closed ☐ Both ☐ with bite registration ☐ with splint ☐ with Stent
☐ Other

Special Instructions:_____

By signing below I request The Dental Scan Center and it's associates to acquire the images I have requested. I have obtained authorization from the patient for these procedures. I understand that all images I receive are DICOM Images only with no Interpretation of the data.

Referring Dr. (Print Name)_____ Dr's Email_____

Phone Number_____ Dr's Fax_____

Dr. Signature_____ Date_____

Address_____ Patient Signature_____

☐ Mail CD to Office ☐ Give CD to Patient