



Patient's Name _____ () _____ / / _____ \$
 Patient's Phone Number _____ Date of Birth _____ Appointment Date / Time _____ Fee Estimate _____

Call to schedule appointment. Fee due at time of service.

3-D Cone Beam CT Scan

- Orthodontic / Craniofacial Study**
- Corrected panoramic view
 - Lateral ceph, frontal ceph view
 - 3-D Volumetric view
- Beginning
 Progress
 Final

Optional: includes your choice of two of the following

- Tracing analysis of lateral/frontal views
 Closed TMJ views
 Dental impaction views (Tooth # _____)
 Volumetric airway views

Temporomandibular Joint Study

- Closed right & left views (9-images)
- Corrected panoramic view
- Submental view

Optional / Additional views on request

- Open Mouth
 Rest
 With intraoral appliance/bite registration
 3-D volumetric skeletal view
 Radiologist Interpretation/Report

Implant Study (indicate interest areas)

- 3-D Volumetric skeletal view
- Corrected panoramic view

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

- Implant/Nobel Guide - Dicom**
 Impaction Study (Tooth # _____)
 Infection/Cyst (by location) (Tooth # _____)
 Paranasal Study
 Volumetric Airway Study
 Sleep Study
 Radiologist Interpretation/Report

Clinical Photography/Imaging/Models

- Intraoral & Extraoral Digital Photo Series**
 Custom Rx _____
 3-D Surface Imaging
 Plaster Models
 Digital Models
 Digital Models with Virtual Setup

Radiography Studies

- Beginning Progress Final
 Panoramic radiograph
 Ant PA's FMX Posterior BTW
 Lateral ceph Frontal ceph
 Tracing Analysis
 90° Mandibular occlusion 90° Max occlusion
 Carpel Index Height Analysis
 Other _____

Temporomandibular Joint Radiography (available by request)

- Right & Left corrected Tomography Centric relation
 Other _____ Centric occlusion
 With appliance/Closed
 Open Rest
 Closed

- Dicom Scan to Disk** **Reports Scan to Disk** **I-CAT Vision**

Dr's Signature _____ Date _____

Date of next appointment _____