3DCT MOBILE IMAGING
Toll Free 1 (844)900-3328
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3DCTMOBILE.COM

PLEASE PRINT CLEARLY IN ALL FIELDS

Patient Name: _____

Practice Name: _____

Referring Doctor: _____

Office Address: _____

City: _____ **Zip Code:** _____

Phone Number: _____

Email _____

Format Options (Please Check)

- ☐ NNT
- ☐ Free Viewer(SimPlant *CAT Vision NNT)*
- ☐ DICOM (For *NobelGuide, EasyGuide, VIP, iDent & Otther)*

NewTom Cone Beam CT Scan

Implant Survey

Maxillary Arch
- ☐ Tooth # _____
- ☐ Entire Arch

Mandibular Arch
- ☐ Tooth # _____
- ☐ Entire Arch

- ☐ Teeth in Occlusion
- ☐ Teeth Separated
- ☐ Pt Wears Stent
- ☐ Scan Stent Alone
- ☐ Splint In

☐ Impacted Teeth

Tooth # _____

- ☐ TMJ Survey
- ☐ Closed Only (Transaxial Included)
- ☐ Open/Closed
- ☐ At Rest

☐ Pathology

Tooth # _____

- ☐ Panorex
- ☐ Orthodontic Scan (DICOM)
- ☐ C-Spine

3rd Party Companies _____

☐ DICOM For Guided Surgery

Right

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

☐ Radiologist Report *Recommended* (Additional Fee) (Additional Fee)

AUTHORIZED SIGNATURE _____

Special Instructions: _____