



Patient Name:	Age:	Date of Birth:
Home Phone:	Cell Phone:	
Appt. Date:	Appt. Time:	

Referring Dentist:	Dentist Phone:
Relevant Clinical/Dental/Medical History:	

Please select required clinical services:
<input type="checkbox"/> Implant Planning: Arch: <input type="checkbox"/> Maxilla <input type="checkbox"/> Mandible <input type="checkbox"/> Both Specific Sites: _____ Notes: _____ <input type="checkbox"/> Check here if data will be used in 3 rd party software for planning or diagnostic purposes Please indicate software: _____
<input type="checkbox"/> TMJ Assessment Arch: <input type="checkbox"/> Closed Only <input type="checkbox"/> Open and Closed <input type="checkbox"/> Closed with splint
<input type="checkbox"/> 3rd Molar/Impacted Teeth: Arch: <input type="checkbox"/> Maxilla <input type="checkbox"/> Mandible <input type="checkbox"/> Both
<input type="checkbox"/> Orthodontics
<input type="checkbox"/> Sinus Evaluation
<input type="checkbox"/> Pathology Arch: <input type="checkbox"/> Maxilla <input type="checkbox"/> Mandible <input type="checkbox"/> Both
<input type="checkbox"/> Airway/ Sleep Apnea
By signing below, I state that this procedure is medically necessary for this patient and I request that DentView3D imaging center acquires the images and I have obtained authorization from the patient for these procedures. Doctor Name: _____ License #: _____ **Doctor's email for return of radiologist report: _____ Signature: _____