4400 Buffalo Gap Road, Suite 0475
Abilene, TX 79606
Office 325/232-8692
Fax 325/232-8693
www.imagdent.com

Patient: Please bring this prescription with you!
Doctor: Please keep a copy for your records.

Patient Information:

Referring Dentist: _____ **Appointment Date:** _____

Patient Name: _____ **Patient DOB:** / / **Patient Phone #:** _____

Invoice: ☐ Patient ☐ Doctor

Delivery Options: ☐ Web Delivery ☐ Mail CD/Paper ☐ Rush ($25)

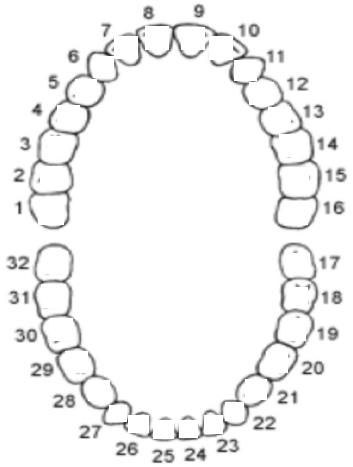
Estimated Cost:$ _____

Please provide ICD 10 Code(s) to help maximize reimbursement:

_____ Primary _____ Secondary

CBCT Services: Includes Free Viewing Software and DICOM

☐ Cone Beam CT Scan
☐ TMJ Open/Closed Cone Beam CT Scan
Additional View: _____



Additional CBCT and Digital Services:

☐ **Print-Outs:** Cross sectional print-outs *(Please mark teeth on tooth chart!)*
☐ **Radiologist Interpretation:** (Provide notes to radiologist in notes section)
☐ **Virtual Implant Planning:** (*Please mark teeth on tooth chart!*)
Default Software: Implant Concierge ☐ Other _____
Implant Brand _____

Orthodontic Packages & Services:

☐ **Ortho Records:** Includes Pano, Ceph, Tracing, Photos, and Study Models
Tracing: _____

☐ **Panoramic**

☐ **Composite 8 Photos**

☐ **Cephalometric:** ☐ Lateral ☐ A-P

☐ **Ceph Tracing:** _____

☐ **Carpal (Wrist)**
Interpretation ☐ Yes ☐ No

☐ **Invisalign Records:** Includes Pano, Photos, PVS Impressions and Bite Reg.

☐ **Digital Ortho Study Models**
☐ Maxilla ☐ Mandible ☐ Both

Notes: Required for Radiology Interpretation

_____

_____

_____

License # **Doctor's Signature:** **Date:** / /