SCANNED____QB____

***** Please remove gum, removable partials, retainers, jewelry or any other metal objects from head and neck areas.*****

MALE / FEMALE

PATIENT NAME ________________________ DATE OF BIRTH ________________

Like us on Facebook!

ADDRESS ________________________ CITY/STATE/ZIP ________________

Follow us on Twitter!

EMAIL ________________________ PHONE ________________

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*THERE IS A $35 FEE APPLIED WHEN ADDITIONAL COPIES ARE REQUESTED

☐ I understand this will only be applied when I request the records

	Y	N
Do you (patient) have any illness that is communicable?	☐	☐
Do you (patient) have any injuries or special conditions that we should be aware of?	☐	☐

Female Patients Only	**Y**	**N**
Is there any possibility that you (patient) are pregnant?	☐	☐

Do you wish to allow OrthoDent3D Imaging to use the images created for study purposes or creating images for display on website/promotional material. All personal information will be removed in that event.

Y ☐ N ☐

If yes, please sign ________________________ Relationship to Patient ________________

FOR OFFICE USE ONLY

1. **DICOM**
_______INV/SS/DATAFRAMES

2. **BASIC SOFTWARE**
________INV/VISION FILE
________SEXTANT STUDIES

3. **PHOTO SERIES**
_______COLLAGE

4. **ORTHO PKG**
________PANO/CEPH
________INV/VISION FILE
________CEPH TRACING

7. **SG/IMPLANT PKG**
_______SCANS UPLOADED
_______IMPLANTS PLANNED
_______SG FORM RECEIVED
_______FINAL PLAN U/L
_______SG SHIPPED

8. **RAD REPORT**
_______SUBMITTED
_______RECEIVED

5. **OBI/TMJ**
_______24 IMAGES
_______RAD SUBMITTED

9. **ITERO**
________INVISALIGN/OTHER
________PHOTOS/PANO/CEPH

10. **RETAINER CLEAR**
________ITERO COMPLETED/RECEIVED
________STL FILE UPLOADED TO__________

11. **VIRTUALLY STRAIGHT**
_______ITERO COMPLETED/RECEIVED
_______STL FILE UPLOADED TO SS
_______# OF STL FILES FOR UPPER – LEVEL _____
_______# OF STL FILES FOR LOWER – LEVEL_____
_______VS APPROVAL FORM RECEIVED
_______STL FILE UPLOADED TO______________

SENT VIA:
_______SHAREFILE
_______EMAIL
_______UPS, 1Z6477VX03_____________
_______TEAMLINKS

NOTES:

PT PAY___________CHECK#________ ☐VISA ☐MC ☐DISCOVER ☐AMEX ☐CARECREDIT

INVOICE____________

i-CAT CBCT INFORMED CONSENT

About i-CAT CBCT Cone Beam Scans

Your referring doctor's office has referred you to OrthoDent 3D Imaging for your 3D scan. The technology is i-CAT Cone Beam Computer Assembled Tomography (CBCT) imaging, sometimes called 3-D radiographs or x-rays. Using CBCT means that we now have the ability to take 3-D images of the teeth, jaws, bones and facial structures at lower costs and with less energy than a typical CT scan used in hospitals. 3-D imaging provides improved diagnosis for our patients, especially in cases of impacted teeth, dental implants, surgical treatment, and even more complex cases. Understandably, you may have questions about exposure to these types of x-rays. Here are some facts you should know about 3-D imaging. **The 8.5 second i-CAT CBCT exposure is**:

- ***About ½ as much as a full series of orthodontic digital images***
- ***About 1/5 as much as a full mouth series of standard dental x-rays (28 films)***
- ***About 1/70 as much as a typical medical CT scan***

CBCT offers our patients enhanced diagnostic value at significantly reduced exposure. Simultaneously, CBCT scans can image the entire head and most of the neck. As a dental specialists, your doctor evaluates teeth, jaws and the surrounding bone using CBCT's for those limited purposes. Their training and dental license does not provide for evaluation and diagnosis outside of those areas. **Since CBCT imaging can cover a broader area, we want to offer you the opportunity to have your CBCT scan read by an oral radiologist who is trained and licensed to evaluate and diagnose a broader area. A CBCT may show evidence of disease of the cervical spine, skull or arteries. We can refer you to a radiology group for this purpose.** The cost is $100. If you are interested in taking advantage of this service, please initial the applicable section and sign the acknowledgement below.

(   ) **Yes**, I want to have my i-CAT CBCT scans read by an oral radiologist for $100. I understand that I am responsible for this additional cost.

(   ) **No**. I understand the risks and benefits of having my CBCT read and interpreted by an oral radiologist. However, I am knowingly declining such a referral.

____
Print Patient Name

____
Signature of Responsible Party

____
Date