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www.orthodent3d.com
forms@orthodent3d.com

Patient: DOB: Phone#:
Date of Referral: Referred by:
Appointment Date/Time: Estimated Cost: patient pay **OR** invoice office

OrthoDent 3D Imaging utilizes a HIPAA compliant online database, private to each of our referring offices. Please provide us with an email address so we can synchronize our share filing IF you have not yet supplied us with this information.

EMAIL ADDRESS

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IMPLANT/RESTORATIVE STUDIES

3D CBCT Scan (DICOM only. Please select IF you have your own viewing software)

Basic Formatting with Viewing Software

Surgical Guide Scan Package with Virtual Implant Planning (please check needed items)

***surgical guide will be directly billed from Anatomage**

CBCT scan for: patient stone model (please ship model to McKinney location)
InVivo implant planning
iTero digital model scan
Surgical guide

Mandibular Implant (specify site, implant system and size):
Maxillary Implant (specify site, implant system and size):

ORTHODONTIC/ PHOTOGRAPHIC

3D CBCT Scan (DICOM only. Please select IF you have your own viewing software)

SureSmile CBCT scan for upload to SureSmile (Raw DICOM)

Cephalometric Lateral view OR PA view

Lateral Cephalometric Tracing (please specify analysis)

Panoramic

Sextant Study (please specify area of concern)

Photographic Series (8 view, all digital)

iTero Scan for (please select company)

Invisalign (please setup your patient on your Invisalign portal prior to patient's appointment with OrthoDent)
Other Clear Aligner companies (STL file will be emailed)
Retainer Clear
SureSmile
SureSmile Elemetrix

SPECIAL STUDIES

Dentistry's Optimal Model of Health (DOM)
Orthognatic Bioesthetic Institute (OBI)
The Stewart Center
Additional Review by Radiologist (clinical narrative needed in comments section)

3D PRINTED MODELS

STL file uploaded to www.orthodent3d.com (select if you have your own scanner)

Upper model	Lower model
Horseshoe model	Horseshoe model
Low-Profile Palate ABO Base	Low-Profile Palate ABO Base
Movement (please specify in comments section)	Movement (please specify in comments section)

Comments:

REFERRING DOCTOR SIGNATURE (REQUIRED) ______________________ TEXAS DENTAL LICENSE # ____________

By signing above, I state that this procedure is medically necessary for this patient, and I request that OrthoDent 3D Imaging acquire the listed images, and that I have obtained authorization from the patient for these procedures.