3D X-Ray CBCT Imaging Request

Please bring this Imaging Prescription with you on the day of your appointment

Patient Name:_____ Age_____ Date of Birth:_____
Patient Phone #_____

Delivery Options:
( ) Hand Carry: DICOM Data CD (with iCat Vision Software and DICOM Files) given patient to hand carry your office
( ) Mail to Office: DICOM Data CD (with iCat Vision Software and DICOM Files)
( ) Secure Email Link: *DICOM Files only (####.dcm)*

Radiograph:
( ) Standard TMJ, Sinus, Impaction, Other Evaluation: Chin to Orbit Scan 0.3mm Voxel
( ) Endodontic Evaluation: Single Arch Scan 0.125mm Voxel
( ) Implant Planning*: Dual Arch Scan 0.2mm Voxel

**For Implant Planning only:*
Is the patient coming with a study model to be scanned? [ ] No [ ] Yes - Scan patient & model w/Anatomage Guide Protocols
Is the patient coming with a radiographic prosthesis? [ ] No [ ] Yes - Scan patient with AND without prosthesis in place
[ ] Yes - Scan patient only with the prosthesis in place

All patients will be imaged in centric occlusion bite unless otherwise directed (Requests for images under the Anatomage Guide Protocols will have patients imaged with teeth separated as per protocol)
Please mark any region of interest if applicable:

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

Special Instructions: _____

_____

_____

3D Study Model Scan: *Note: When taking 3D Radiographic X-Ray above there is no additional fee for this service*

iTero Scan iRecord for STL files. [ ] No [ ] Yes (Secure Email link will be used to send STL files)
Notes:_____

Chenin Orthodontics is only providing the technical service of enabling referring doctors to utilize radiologic equipment by order of this written request. Chenin Orthodontics, its doctors, or agents are not responsible for image interpretation, readings, or diagnostic findings. The diagnosis and treatment planning is the sole responsibility of the referring doctor.

By signing below, I request Chenin Orthodontics to acquire the images and I have obtained authorization from the patient for these procedures.

Dr. *(Print Name)*:_____Lisc#:_____Phone:_____
Signature:_____

PATIENT INFORMATION

Appointment Date _____ Appointment Time:_____

Appointments

- Please give 24 hours notice if you need to cancel your appointment.
- Please arrive at least 10 minutes prior to your appointment time. If you are late, 15 min or more, then it may be necessary to reschedule your appointment.
- All images will be delivered to the referring doctor as directed.

Insurance

Fees for images are payable at the time of your appointment. We do not accept assignment of benefits for this procedure. You will be provided with the necessary information for possible reimbursement for your insurance carrier. Contact your insurance carrier for coverage.

Pregnancy

If you are pregnant, or think you may be pregnant, contact your physician prior to scheduling your appointment.

Chenin Orthodontic Group | **Henderson**
10730 S. Eastern Ave.
Suite 100
Henderson, NV 89052
702.735.1010

Chenin and Thalgott Orthodontics | **Summerlin**
1945 Village Center Circle
Suite 110
Las Vegas, NV 89134
702.364.5100

Email: info@cheninOrtho.com