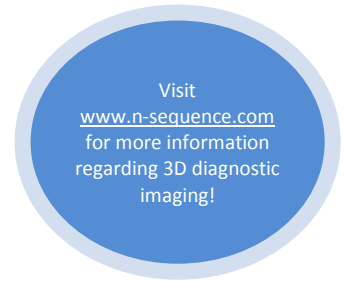


**Note: Referring Dentist must provide an email address, complete & sign the bottom of this form.**

Patient Name:	Age:	Date of Birth:
Home Phone:	Work Phone:	
Appointment Date*:	Appointment Time*:	

**\*Appointments and payment arrangements (ie: either patient to pay at time of service or dentist to be invoiced) are to be made by the referring dentist only. Please contact nSequence 3D Diagnostic Imaging Center for scheduling and pricing information.**

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



### 3D Cone Beam Volumetric Dental Imaging

Please select any applicable clinical objectives: <i>(Scan data will be placed on a CD containing i-CAT Vision viewing software)</i>	Image workup portfolio <i>(Additional charges)</i>
<input type="checkbox"/> <b>Implant Planning:</b> <ul style="list-style-type: none"> <li>Arch: <input type="checkbox"/> Maxilla <input type="checkbox"/> Mandible <input type="checkbox"/> Both</li> <li>Specific Site(s): _____</li> <li>Notes: _____</li> </ul> <input type="checkbox"/> Check here if data is to be used in a 3 <sup>rd</sup> party software application for planning or diagnostic purposes <b>Please indicate software to be used:</b> _____	<input type="checkbox"/> Yes
<input type="checkbox"/> <b>TMJ Assessment:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Closed Only <input type="checkbox"/> Open and Closed <input type="checkbox"/> Closed with splint</li> </ul>	<input type="checkbox"/> Yes
<input type="checkbox"/> <b>3<sup>rd</sup> Molar/Impacted teeth:</b> <ul style="list-style-type: none"> <li>Arch: <input type="checkbox"/> Maxilla <input type="checkbox"/> Mandible <input type="checkbox"/> Both</li> <li>Specific Site(s): _____</li> </ul>	<input type="checkbox"/> Yes
<input type="checkbox"/> <b>Orthodontics</b>	<input type="checkbox"/> Yes
<input type="checkbox"/> <b>Cephalometric Images &amp; Tracings</b>	<input type="checkbox"/> Yes
<input type="checkbox"/> <b>Sinus Evaluation</b>	<input type="checkbox"/> Yes
<input type="checkbox"/> <b>Pathology:</b> <ul style="list-style-type: none"> <li>Arch: <input type="checkbox"/> Maxilla <input type="checkbox"/> Mandible <input type="checkbox"/> Both</li> <li>Location/working description: _____</li> </ul>	<input type="checkbox"/> Yes
<input type="checkbox"/> <b>Air Way / Sleep Apnea</b>	<input type="checkbox"/> Yes

Notes:

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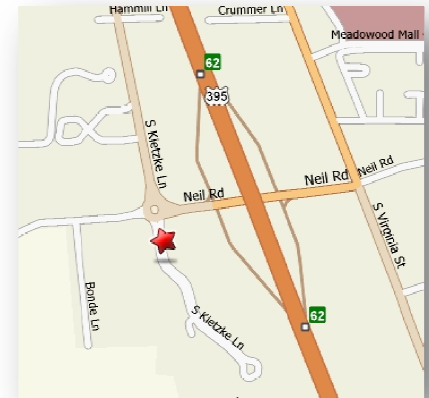
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**By signing below, I state that this procedure is medically necessary for this patient and I request that nSequence 3D Diagnostic Imaging acquires the images and I have obtained authorization from the patient for these procedures.**

Doctor Name: \_\_\_\_\_  
 License #: \_\_\_\_\_

\*\*Doctor's email for return of radiologist report: \_\_\_\_\_

Signature: **X** \_\_\_\_\_

*nSequence 3D Diagnostic Imaging is not licensed to diagnose, interpret, or treatment plan the images from any scan. Therefore, we have each initial patient scan sent to a Board Certified Oral & Maxillofacial Radiologist for a written report of any secondary findings in the scan volume. **This valuable service is included in the price of the initial scan and the completed report will be delivered (in PDF format) to the referring dentist, via email, within 5-7 business days of the scan.***