PatientName: ………………………………………………………… Date of Birth: …………………………………………………………

Contact No…………………………………………………………………. Email: ………………………………………………………………….

Referral Doctor’s Name & Address: ………………………………………………………………………………………………………….

………………………………………………………………………………………………………………………………………………………………….

**Endodontics Rayscan Digital Imaging (check of the following)**

1. Single (up to 4 adjacent sites) Area Specific: ……….……………………………………………………
2. One Arch
3. Two Arches
4. TMJ Surgical Stent: Yes No

 

**Service Desired: (check one of the following –** referrals without check the following will auto default as option #2 – **Full Set – See fee guide for fee references)**

1. Dicom Only (Taking Image + Interpretation Report + CD)
2. **Full Set** (Includes Taking Image + Print out + Interpretation Report + CD)
3. Full Set with Measurement (All of the above + Print out with measurements)
4. Rush Case ($70 Fee will apply – 1 day turnaround time)

Special Instruction: ……………………………………………………………………………………………………………………..

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Referring Doctor’s Signature………………………………………………………….Date: …………………………………..

BROKEN APPOINTMENT FEE $75 (for less than 48 hrs notice)