Dani Dental imaging

Patient Prescription Form

Patient Information

Patient Name | DOB | Phone

Email | Address | City/State/Zip

Doctor Information

Doctor's Name

Address

City | State | Zip

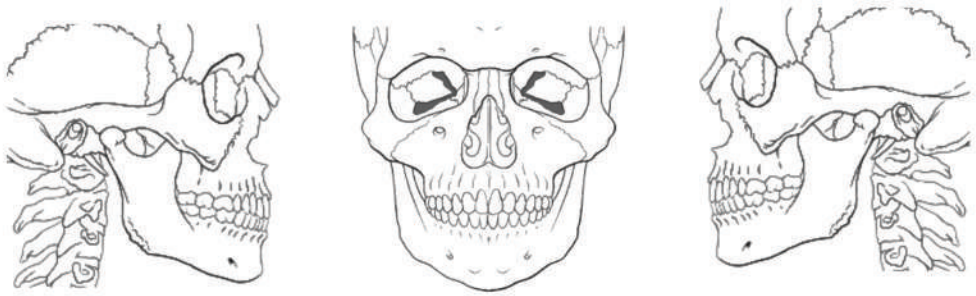
Office Phone | Fax | Email

Appointment Information

Appointment Date/Time

1. Please bring prescription slip with you
2. Fees for service is due at time of appointment
   - ☐ *Patient Pay* ☐ *Doctor Pay*
3. Patients are seen by appointment only
4. Please remove all jewelry from head or neck for appointment

Circle Region of Interest



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

- ☐ Maxillary
- ☐ Mandibular
- ☐ Implant Scan
- ☐ Volumetric Airway/Sinus Scan
- ☐ Impaction Scan
- ☐ Infection/Cyst Scan
- ☐ Dual Scan Protocol
- ☐ TMJ Scan
  - ☐ Closed ☐ Rest
  - ☐ Open ☐ With Appliance
- ☐ Panoramic Radiograph Scan
- ☐ Orthodontic/Craniofacian Scan*

**Orthodontic Scan includes: Photographs, Panorex, Lateral Cephalometric, Tracings and your choince of two:*

☐ Frontal Ceph ☐ Closed TMJ ☐ Impaction Study ☐ Airway Study

Doctor Signature | Date

*I hereby assume responsibility for anything that is found within or as a result of the scan. I agree that Dani Dental Studio is strictly providing a service to me by providing the scan and therefore is not responsible for anything found in or as a result of the said scan

Post Scanning Services

- ☐ Provide DICOM File Only
- ☐ Provide DICOM File with PreXion3D Viewer Software
- ☐ **Provide a Radiology/Pathology Report**
- ☐ Implant Treatment Planning (coDiagnostiX)

Radioactive Studies

- ☐ Digital Photography
  - ☐ Full Facial Protocol