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Front

Appointment Information: This time is reserved specifically for you. If by necessity, you must cancel your appointment, please notify our office at least 48 hours in advance.

Today's Date: _____ Appt. Date: _____ Time: _____

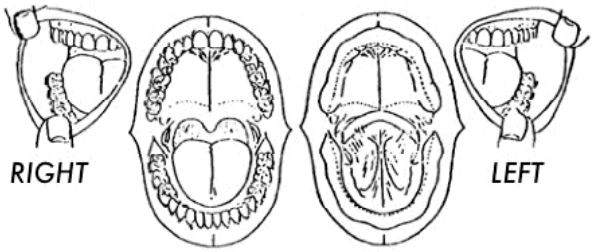
Patient's Name: _____

Patient's Phone: _____

Referring Dr.'s Name: _____

Referring Dr.'s Phone: _____

SOFT TISSUE CHART



PLEASE CIRCLE OR MARK (X) TEETH TO BE TREATED

RIGHT															LEFT
			A	B	C	D	E	F	G	H	I	J			
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
			T	S	R	Q	P	O	N	M	L	K			

❑ EXTRACTION
- ❑ Lesion & Evaluation
- ❑ Incision & Drainage
- ❑ Exposure
- ❑ Biopsy
- ❑ Expose & Bond
- ❑ Frenectomy
- ❑ Other: _____

RADIOGRAPHS:
- ❑ Being Mailed
- ❑ Given to Patient
- ❑ Please Take
- ❑ No X-Ray
- ❑ Will Bring X-Ray
- ❑ Other: _____

CONSULTATION:
- ❑ Implants
- ❑ Bone Grafting
- ❑ Wisdom Teeth
- ❑ Jaw Surgery
- ❑ TMJ
- ❑ Facial Reconstruction
- ❑ Facial Aesthetics
- ❑ Pathology
- ❑ Snoring & Sleep Apnea

Comments / Special Instructions: _____

PLEASE SEE REVERSE SIDE FOR i-CAT REFERRAL AND ADDITIONAL INSTRUCTIONS

Back

i-CAT 3D Imaging Referral Form

Referring Doctor: _____

Reason for Study/History: _____

_____

Area of Interest/Comments: _____

_____

_____

iPAN
❑ Standard Panoramic View

Cone Beam CT Volume Scan
❑ i-CAT Reconstructed Panoramic View (anatomically correct)
❑ Implant (NobelGuide Scan)
❑ Implant (General View)
❑ Maximum Resolution (8 cm x 6 cm) scan
❑ Maxilla (list area for imaging slices)
❑ Mandible (list area for imaging slices)
❑ Both maxilla & Mandible (list area for imaging slices)
❑ TMJ Complete
❑ TMJ Limited
❑ Sinus
❑ Orthodontics
❑ Extended Field of View

Reports ❑ Printed ❑ i-CAT Vision CD ❑ DICOM CD

❑ PDF - email: _____

Please Read This Important Information Before Your Appointment:

Your first appointment will often be a consultation appointment to determine your specific treatment needs.
Please bring all medical and dental insurance information with you.
If you take any medications or prescriptions regulary, please bring a list of the medications, the dose and frequency of each.
A parent or legal guardian must accompany patients 17 years old or younger.
If you must change your appointment we ask that you notify us 48 hours in advance as a curtesy to other patients.
If you have been given X-rays, please bring them along with this referral slip.

Sedation Instructions:
If your appointment is between 8:00 am and 2:00 pm and you would prefer to be sedated for your surgery, **TAKE NO FOOD OR LIQUIDS AFTER MIDNIGHT** the night before surgery.

If possible remove your contact lenses prior to your appointment and wear loose comfortable clothing.

YOU MUST BE ACCOMPANIED BY SOMEONE TO DRIVE YOU HOME AND STAY WITH YOU FOR SEVERAL HOURS.

It may be necessary to reschedule your appointment if there are unexpected medical findings or a change in the proposed dental surgery.

❑ Radiological Report - Type _____
Please note that it is the responsibility of the referring doctor for diagnosis and management of any information produced by these images. Radiological referral available (check box above).