RX FORM

OFFICE: 561-278-6700
FAX: 888-865-0664
www.digiscanfl.com
Mobile CBTC

PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home phone: _____ **Cell phone:** _____ **E-mail:** _____

REFERRING DOCTOR INFORMATION

Doctor Name: _____ **Cell:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Office Phone: _____ **Fax:** _____ **E-mail:** _____

SCHEDULING INFORMATION

Appointment date: _____ **Time:** _____ **Location:** Doctor's Office ☐
Address: _____ **City:** _____ Patient Home or Office ☐

IMPLANTS:
Implant Area: Mandibule _____ Maxilla _____ Both _____
Is your Patient coming with a radiographic template: Yes No ☐

SERVICES:
Radiology Report
Yes ☐ **No** ☐
CHARGE $85.oo

(Indicate teeth or area 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

ADDITIONAL
Do you have an implant Planning Software YES ☐ Name _____ NO ☐
Preferred Format: CD-ROM ☐ Dropbox – E-mail ☐
Special Instruction:

_____
_____
_____

- ☐ Implant Planning
- ☐ Sinus Assessment
- ☐ Inferior Alveolar nerve
- ☐ Third Molar Assessment
- ☐ Endodontic Surgery
- ☐ Oral Pathology Assessment
- ☐ Airway / Sinus Assessment
- ☐ Sleep Apnea Study
- ☐ TMJ Assessment

Guided Implant Surgery System
Nobel ☐ Simplant ☐ Blue Sky ☐
IDent ☐ Keystone ☐
Other: _____
Comments: _____

Payment Information:
Total Charges for Above Checked Services: **$ 375** **Responsible Party**: Patient ☐ Doctor ☐
All payments for CBCT Scans will be due in full when services are rendered. If the referring Doctor is responsible for payment, Please provide payment confirmation prior to the appointment; otherwise the patient will be responsible for the payment

Authorization / Acknowledgement:

Referring Doctor (print name) _____ Signature: _____ Date: ____/____/____
(Required)

DISCLAIMER: The above referring Doctor acknowledges and agree that interpretation of the CBCT Scan, including but not limited to the Data reformatting, diagnostics and treatment planning are the purpose of assisting the Referring Doctor/Clinical and/or radiologist in diagnosis and pre-surgical planning, decisions and interpretations are solely the responsibility of the referring Doctor. The referring Doctor understands and agrees that DigiScan of Florida, LLC is not responsible for providing any interpretation of the CT images, and therefore waives, releases and discharges DigiScan of Florida, LLC from any and all claims relating to the diagnosis and treatment and any pathology findings of Patient.

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PATHOLOGY REPORT REQUEST

Patient Name: _____

Address: _____

_____

Date of Birth: ____/____/_____ **Sex: Male ☐ Female ☐**

Doctor Name: _____

Office Phone: _____ **Fax:** _____

E-mail: _____

Date ___/___/_____ **Exam Date:** ___/___/_____

GP ☐ Endo ☐ ENT ☐ OS ☐ Ortho ☐ Ped ☐ Perio ☐ Other ☐

TO BE COMPLETED BY THE PHYSICIAN / DENTIST

Pertinent History:

_____

_____

_____

Sings, Symptoms, Relevant Diagnosis:

_____

_____

_____

Specific question (s) to be answered by this study:

_____

_____

_____

Patient Pregnant: YES ☐ NO ☐

Payment Information:
Total Charges for Pathology Report Services: $85.oo **Responsible Party: Patient ☐ Doctor ☐**

Referring Doctor (print name) _____ **Signature:** _____
(Required)