Mobile CBCT
www.digiscanfl.com - Office: 561-278-6700 - Fax: 888- 865-0664

RX FORM

PATIENT INFORMATION

Patient Name: _____ Date of birth:_____/_____/_____
Address:_____City:_____State:_____ Zip Code:_____
Home Phone:_____Cell Phone:_____E-mail:_____

REFERRING DOCTOR INFORMATION

Doctor Name:_____Cell Phone:_____
Address:_____City:_____State:_____ Zip Code:_____
Office Phone:_____Fax: :_____E-mail:_____

SCHEDULING INFORMATION

Appointment date:_____/_____/_____ Time:_____ Address:_____
Location: Doctor's Office ☐ Patient Home or Office ☐\

IMPLANTS

Implant Area: Mandible ☐ Maxilla ☐ Both ☐
Is your patient coming with a radiographic template: Yes ☐ No ☐

(indicate teeth or of interest)

1 2 3 4 5 6 7 8 ☐ 9 10 11 12 13 14 15 16
----------**area** ----------
32 31 30 29 28 27 26 ☐ 24-23 22 21 20 19 18 17

SERVICES

Radiology Report: Additional Charge $85 25
Yes ☐ No ☐
Do you have an implant planning software? Yes ☐ No ☐
Preferred format: CD- Rom ☐ Dropbox (e-mail) ☐
Special instructions:

_____
_____
_____
_____

Implant Planning☐ Sinun Assessment☐ Inferior Alveolar Nerve☐ Third Molar Assessment☐
Endodontic Surgery☐ Oral Pathology Assessment☐ Airway/Sinus Assessment ☐ TMJ Assessment☐

Guide 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: ___/___/_____
DISCLAIMER: The above referring doctor acknowledges an 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 and diagnosis and presurgical 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 the patient.

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PATHOLOGY REPORT REQUEST
(Additional Charge)

PATIENT INFORMATION

Patient Name: _____ Date of birth:_____/_____/_____
Address:_____City:_____State:_____ Zip Code:_____
Sex: Male ☐ Female ☐

DOCTOR INFORMATION

Doctor Name:_____Exam Date:_____/_____/_____
Office Phone:_____Fax: :_____E-mail:_____

TO BE COMPLETED BY THE PHYSICIAN / DENTIST

Pertinent History:
_____
_____
_____

Sings, Symptoms, Relevant Diagnosis:
_____
_____
_____

Specific questions to be answered by this study:
_____
_____
_____

Patient pregnant: Yes ☐ No ☐

Payment Information:
Total charges for the radiology report services : $85 Responsible party: Patient ☐ Doctor ☐

Referring Doctor (print name)_____Signature:_____
Date:_____/_____/_____