DigiScan of Florida, LLC

OFFICE: 561-278-6700
FAX: (1) 888-865-0664
(2) 561-272-4174
www.digiscanfl.com
Mobile CBCT

RX FORM

PATIENT INFORMATION

Patient Name:_____ **Date of Birth:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Cell Phone:**_____ **Email:**_____

REFERRING DOCTOR INFORMATION

Doctor Name:_____ **Cell #**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Office#:_____ **Fax#**_____ **Email:**_____

SCHEDULING INFORMATION

Appointment date:_____ **Appointment Time:**_____

Address:_____ **City:**_____

Circle One — **Location**

❑ **Doctor's Office**
❑ **Patient Home 0r Office**

IMPLANTS:

Implant area: Mandible_____ Maxilla_____ Both_____

Is your patient coming with a radiographic template? Yes ❑ No ❑

(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

SERVICES:

❑ **Radiology Report**
Yes No (circle)

CHARGE $85.00 ADDITIONAL!

❑ Do you have an implant planning software? ❑ Yes ❑ No
If Yes specify: _____

Preferred Format

❑ CD-ROM
❑ Internet

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 Guide ❑ Simplant ❑ Blue Sky
❑ IDent ❑ Keystone ❑ Other:_____

❑ Comments:_____

Payment Information:

Total Charges for Above Checked Services: $ 375.00 **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 payment.

Authorization / Acknowledgement:

Referring Doctor (Print)_____ **Signature:**_____ **Date:**_____
(Required)

DISCLAIMER: The above referring Doctor acknowledges and agrees that interpretation of the CBCT Scan, including but not limited to the Data reformatting, diagnostics, and treatment planning are for the purpose of assisting the Referring Doctor /Clinician 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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Delray Beach, FL 33445
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Patients Name: _____

Address: _____

_____

_____

Date of Birth ____/____/____ **Sex:** ❑ **Male** ❑ **Female**

***Doctor*:** _____
First Name Last Name

❑**GP** ❑**Endo** ❑**ENT** ❑**OS** ❑**Ortho** ❑**Pedo** ❑**Perio** ❑**Other**

Address: _____

_____

Phone: _____

Fax: _____

Email: _____

Today's Date _____

Exam Date _____

PATHOLOGY REPORT REQUEST

If requested: Then additional $85.00 Charge!

TO BE COMPLETED BY PHYSICIAN/DENTIST

Pertinent History: _____

_____

_____

Signs. Symptoms, Relevant Diagnosis: _____

_____

_____

_____

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

_____

_____

_____

Patient pregnant? ❑ **Yes** ❑ **No**

Physician/Dentist (print):

_____
First Name Last Name

Physician/Dentist Signature: ***(required)***