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 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: Additional Charge $85
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:_____/_____/_____