REFERRAL FORM

Dental CT Scan (CPT 70486)

Date:____________________________

Phone: **404 236 7700**

Fax: **404 236 7701**

Patient Name: ____________________

Doctor Name: ____________________

Office Phone:___________________ **Cell Phone:** ___________________

Contact us today to schedule an appointment.

CaseType: (select one)

- ❑ **Implant**
- ❑ **Impaction**
- ❑ **Supernumerary**
- ❑ **Pathology**
- ❑ **Sinus**
- ❑ **TMJ Study**
- ❑ **Ortho**
- ❑ **Other**

Conversion: (select one)

❑ **360dps** ❑ **SimPlant**

- -

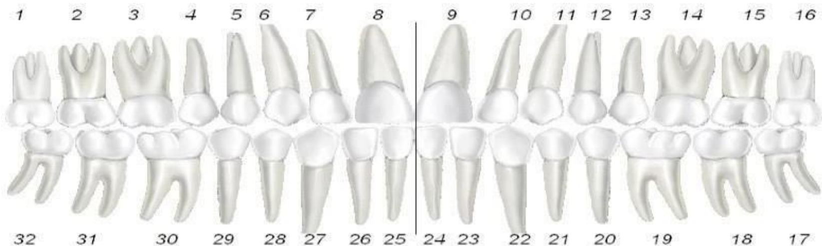
❑ **PilotPlan**™

❑ **Tx vision**™: (Complete this section only if you want treatment planning)

Implant Type:___________________ **Sites Per Arch:** ___________________

Region of Interest

❑ **Quad Only** ❑ **Max** ❑ **Mand**



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Location

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For more detailed directions please visit:
www.360imaging.com/contact-us/

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