Imaging Request

Please bring this Imaging Prescription with you on the day of your appointment

Patient Name:_____ Age_____ Date of Birth:_____

Patient Phone #_____

Image Delivery:

3D X-Ray data will be sent secure email link via www.InvivoWorkspace.com viewer: DICOM Files (####.dcm)

Note: We will send the files to the email address associated with your office unless otherwise noted below:

_____

1. Radiograph:

( ) Standard TMJ, Sinus, Impaction, Other Evaluation: Chin to Orbit Scan 0.3mm Voxel (Scan with bite in occlusion)

( ) Endodontic Evaluation: Single Arch Scan 0.125mm Voxel (Scan with bite in occlusion)

( ) Implant Planning*: Dual Arch Scan 0.2mm Voxel (Scan occlusion varies, see below)

**For Implant Planning only* *Please complete all questions below:*

Is the patient coming with a study model to be scanned? [ ] No [ ] Yes - Scan patient & model w/Anatomage Guide Protocols

Is the patient coming with a radiographic prosthesis? **or** [ ] No [ ] Yes - Scan patient with AND without prosthesis in place
[ ] No [ ] Yes - Scan patient only with the prosthesis in place

Scan patient: [ ] With teeth in centric occlusion [ ] With teeth slightly separated (out of occlusion)
Scan patient: [ ] Resting tongue/cheek position [ ] With cotton rolls separating tongue/cheek/lips from region of interest

Please mark region 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

Special Instructions: _____

_____

_____

2. iTero Scan: *Note: When taking 3D Radiographic X-Ray above there is no additional fee for this service*

[ ] No [ ] Yes - If yes: [ ] Study model scan or [ ] Patients Teeth in normal centric occlusion

iTero iRecord Scan for STL files. (Secure Email used to send STL files)

Notes:_____

Chenin Orthodontics is only providing the technical service of enabling referring doctors to utilize radiologic equipment by order of this written request. Chenin Orthodontics, its doctors, or agents are not responsible for image interpretation, readings, or diagnostic findings. The diagnosis and treatment planning is the sole responsibility of the referring doctor.

By signing below, I request Chenin Orthodontics to acquire the images and I have obtained authorization from the patient for these procedures.

Dr. *(Print Name)*:_____Lisc#:_____Phone:_____

Signature:_____

PATIENT INFORMATION

Appointment Date _____ Appointment Time:_____

Appointments

- Please give 24 hours notice if you need to cancel your appointment.
- Please arrive at least 10 minutes prior to your appointment time. If you are late, 15 min or more, then it may be necessary to reschedule your appointment.
- All images will be delivered to the referring doctor as directed.

Insurance

Fees for images are payable at the time of your appointment. We do not accept assignment of benefits for this procedure. You will be provided with the necessary information for possible reimbursement for your insurance carrier. Contact your insurance carrier for coverage.

Pregnancy

If you are pregnant, or think you may be pregnant, contact your physician prior to scheduling your appointment.

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