3T IMAGING

9000 Waukegan Road Suite # 110
Morton Grove, IL 60053
P: 847-213-2700 F: 847-213-2709
www.3Timaging.com

PATIENT'S NAME: _____

DATE: _____ AGE: _____

PATIENT'S PHONE NUMBER: _____

CLINICAL HISTORY/INDICATION: _____

_____

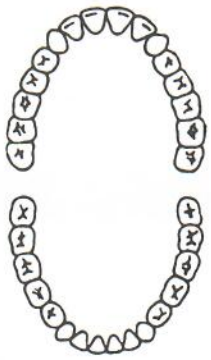
_____

RQI #: _____

Pre-Certification #: _____ ICD-9: _____

DENTAL CT:

- ☐ Maxilla
- ☐ Maxilla including the inferior 2/3 of orbits
- ☐ Mandible
- ☐ Maxilla and Mandible



FOR SIMPLANT STUDIES ONLY

The Platform to Perfection SimPlant

Please send SimPlant Study on a CD-ROM ☐ or via Mail ☐ to: _____

The patient is referred for a Simplant CT scan analysis. The scan should occur so that the axial plane is parallel to the natural teeth or scannoguide template.

The patient ☐ will ☐ will not be wearing negative image scannoguide template during the scanning process.

Physician: _____ Phone #: _____

Physician Signature: _____ Fax #: _____