# Pacific Dental Imaging

Rev 07/15

1040 E. Herndon Ave. #102 Fresno, CA 93720 559-228-9211 559-230-0833 fax

## REFERRAL FORM

*California State law requires this written order to be presented at the time of appointment.

PATIENT _____ AGE _____

ADDRESS _____

*DOCTOR* _____ *APPOINTMENT DATE* _____ *TIME* _____

***WE DO NOT BILL PATIENTS. CASH, CHECK, VISA, OR MASTERCARD ACCEPTED.***
****FEES FOR DENTAL X-RAYS ARE PAYABLE AT THE TIME SERVICE IS RENDERED.****

*INDICATE SPECIFIC AREA OF INTEREST BY CIRCLING THE NUMBER/LETTER*

| 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 |

| Right | A | B | C | D | E | | F | G | H | I | J | Left |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | T | S | R | Q | P | | O | N | M | L | K | |

***Please check procedure requested below:***

☐ **3-D CONEBEAM SCAN - CD Dicom File Only**

**3-D CONEBEAM SCAN Data to be EXTRACTED: ***

- ☐ ***S-1*** Panographic X-ray
- ☐ ***S-2*** Lateral Cephalometric X-ray
  - ☐ ***S-3***: Lateral Ceph Tracing/Analysis
- ☐ ***S-4*** PA Cephalometric X-ray
- ☐ ***S-5*** AP Cephalometric X-ray
- ☐ ***S-6*** TMJ ( 3 views: open, closed, relaxed; Pano: condyle to condyle, & slices of lateral view of each condyle )
- ☐ ***S-7*** Cross-Section Scan: 1 area; indicate area above (implants, impacted, wisdom, etc.)
- ☐ ***S-8*** Cross-Section Scan: Full Arch; indicate arch above
- ☐ ***S-9*** Sinus ( Axial view and Digital Volume Rendering of Lateral Ceph with soft tissue)
- ☐ ***S-10*** Airway (Digital Volume Rendering of Lateral Ceph with soft tissue)

****ALL SCANS AND X-RAY IMAGES(JPG) PROVIDED ON CD UNLESS OTHERWISE INDICATED***

☐ This is my first case please send me my free viewing software so I may view the entire scan.

**FULL MOUTH X-RAYS**

- ☐ ***F*** Full Set (2 copies)
- ☐ ***F-1*** Occlusal X-ray Only
- ☐ ***F-2*** Bitewing X-ray Only
- ☐ ***F-3*** Single Periapical

***D* DUPLICATIONS** Indicate Item(s) & # of copies

☐ **PATIENT PAY** ☐ **DOCTOR BILL**

**SPECIAL PACKAGES**

- ☐ ***1*** Complete Orthodontic Survey (Full Scan, Tracing/Analysis, FMX, Pano, & Photos)
- ☐ ***2*** Limited Orthodontic Survey (Ceph, Tracing/Analysis, Photos)

***P* PHOTOGRAPHIC SURVEY**

- ☐ Standard orthodontic (8 photo layout)
- ☐ Other _____

**SPECIAL ORDERS**

- ☐ ***S-11*** Nerve Canal Tracing
  - ☐ Superior ☐ Inferior: __R__L

***OTHER***

- ☐ ***R-1*** Radiologists Report
- ☐ ***S-14*** Simplant Conversion
- ☐ ***S-15*** Noble BioCare Conversion
- ☐ ***S-16*** 3-D Virtual Treatment Planning Services (Prepared by a Consulting Doctor, available through the planning process. All treatment Plans must be finalized by the Referring Doctor.)
- ☐ ***S-17*** Virtual Models (Digital Model of Upper and Lower with Viewing Software)
- ☐ ***SI-1*** Superimpositions (Indicate photos or 3-D images, before and after, etc. in special instructions)

**SPECIAL INSTRUCTIONS**

***REGULAR DELIVERY w/in 10 BUSINESS DAYS!!***

☐ ***Rush:*** (Extra Fee is Applied-specify date & time)

Doctor Signature:_____ Date:_____


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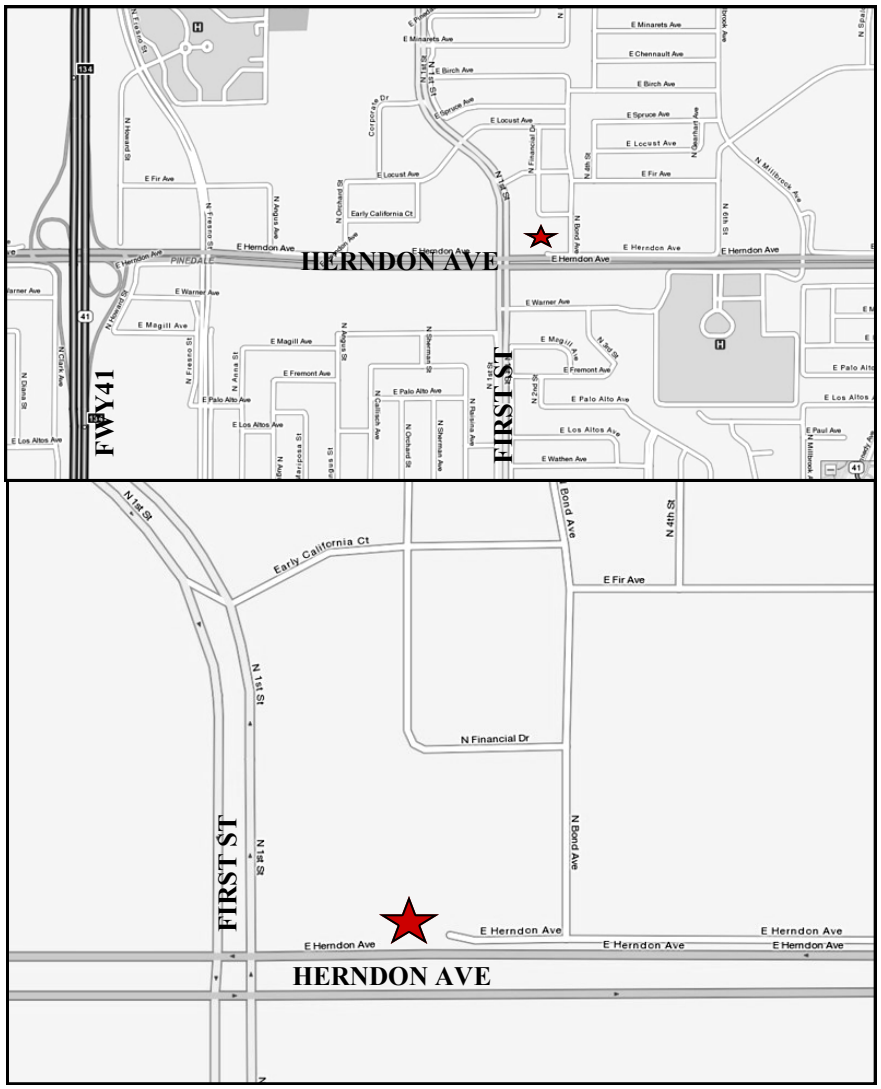
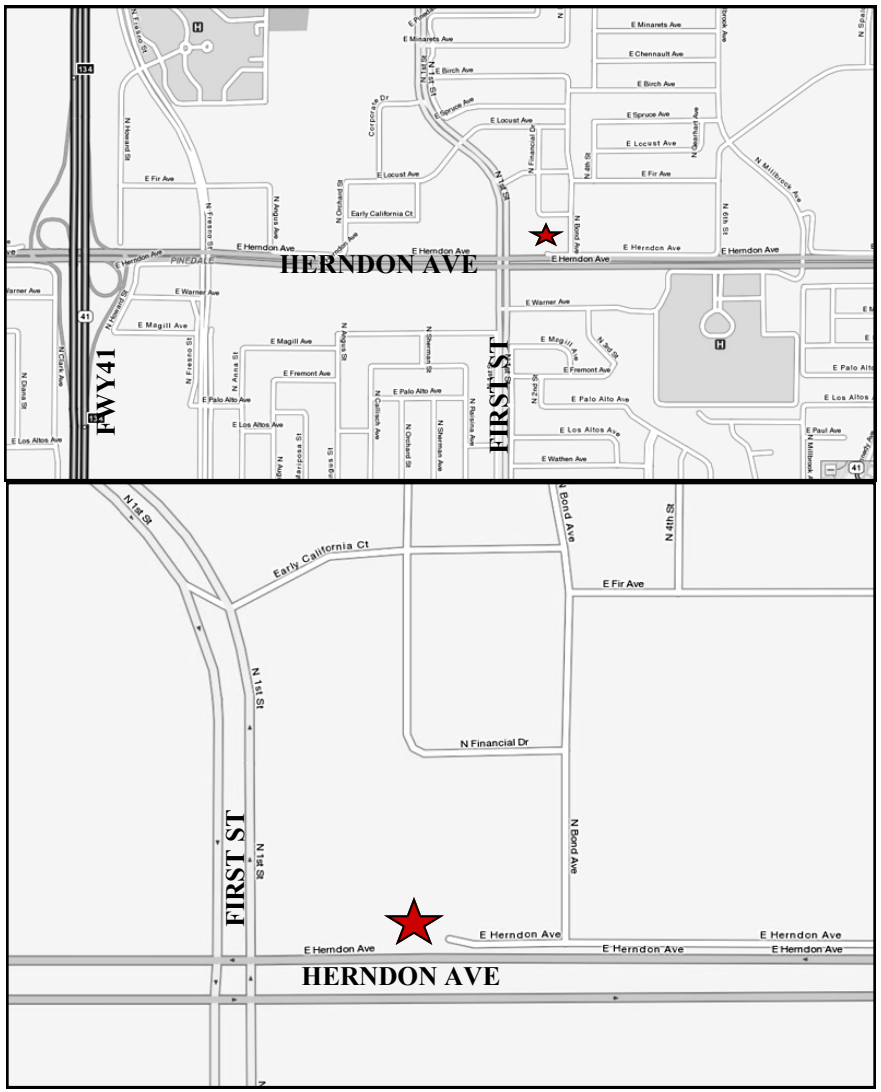



# Pacific Dental Imaging

1040 E. Herndon Ave. #102
559-228-9211 559-230-0833
**Our office is located in the ART OF DESIGN Family & Cosmetic Dentistry office.*

***2nd Building Off the Northeast Corner of Herndon & First-office is located on the Herndon (south) side of the building***

- Easiest to travel **north on First** and **turn right on Early California or Locust** then **right Bond** and then **right on the Herndon frontage** road which will end at the building's parking lot





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