Healthier Smiles Imaging

New Patient Information Referral Form

This is a Prescription, Please Bring it With You

Referring Dentist/Physician_____

Dentist/Physician Phone Number_____

Name_____

Address_____

Phone _____**fax**_____

e-mail_____

Appointment Date_____

Scan to be Hand-delivered_____

Sent to Referring Doctors Office_____

Please send Duplicates to

_____

Please Invoice Doctor_____

Patient_____

Prepaid at Dentist/Physician's Office Confirmed_____

Individual Payment Processing_____ **Cash**_____
Check #_____

Credit Card_____ **Card Type**_____
Card #_____
Expiration Date_____ **Security Code**_____ **Name on Card**_____

Signature of Cardholder_____

Maxilla Only_____ Mandible Only_____
Both Arches_____

Study Packages: Viewing Software and DICOM____
Cross Sectional Print Outs with Viewing Software____

Implant Evaluation____ With Radiographic Prosthesis _____ Impactions/3rd Molar____
Pathology____

TMJ includes Open and Closed____ Airway____

Sinus_____

Virtual Implant Treatment Planning: Software Preference___ Implant Brand____ With Radiologist Interpretation

(Use Special Instructions) Other_____

Diagnostic Reports: Panoramic ____Lateral Cepholometric____

Lic. #_____ Signature_____ Date_____

Please fax this form back to 903-825-7155 or bring with you to your appointment