

PATIENT INFORMATION

Name _____ (First) _____ (MI) _____ (Last) Date of Birth ____/____/____

Sex (circle one) M F Social Security Number _____ - _____ - _____

If Minor, Parent/Guardian Name _____

Home (_____) _____ Work (_____) _____ Cell (_____) _____

Special Instructions:

- STAT CD
 Fax Report Films

EXAMINATION

SimPlant® Dental CT

- Maxilla
 Mandible
 Mandibular Nerve Mapping
 Mandible and Maxilla
 Single Tooth # _____
 Quadrant (circle one) UR UL LR LL

Patient Should:

- Wear a Radiographic Template
 Remove Dentures Before Scan

iCAT Scan

- Sinuses
 Frontal Maxillary
 TMJ (circle) R L
 Closed Open/Closed
 Temporal Bones
 Facial Bones
 Mandible
 Maxilla
 Mandible and Maxilla
 Impaction/Supernumerary
 Other _____

Reason/Symptoms for Exam(s) REQUIRED: _____

Written DX REQUIRED: _____

Medicare and other Insurers require coding of specific/definitive diagnosis(es), sign(s) or symptom(s) to reflect the "medical necessity" for each test. **Rule out, Possible or Probable Conditions cannot be coded.** For Medicare Policy information, see the Part B Bulletin or www.noridian.com/medweb

REFERRING PROVIDER INFORMATION

Signature (required for exam) _____ Date ____/____/____

Referring Provider Name _____ Next Appointment with Patient ____/____/____

Office Phone (_____) _____ Office Fax (_____) _____

Send Images to _____ Format (circle one) Pro View One Shot

Address _____ Phone (_____) _____ Fax (_____) _____

Note: To ensure correct and appropriate patient care and comply with federal rules and regulations, Chicago Dental Imaging's policy is to require a written referral from the treating DDS. The referral (order) must include both a diagnosis (narrative) and signs or symptoms pertinent to the exam requested. For more information, please call (773)582-0706.