MOBILE
3D Advantage, LLC
Your Southern California Premier Dental Imaging Company

Please Call For An Appointment: (949) 282-0083

Fax: (949) 382-1442
Email: mobile3dadvantage@yahoo.com
Website: www.mobile3dadvantage.com

Date of Scan:_____

****ATTENTION PATIENTS****

1. **PAYMENT IS REQUIRED AT TIME OF APPOINTMENT UNLESS DOCTOR TAKES RESPONSIBILITY ON THIS FORM**
2. **3D Advantage does NOT accept assignment of insurance. We will provide a receipt for services rendered.**
3. **24-HOUR CANCELLATION IS REQUIRED OR A FEE WILL BE APPLIED.**

Doctor's Office Only

PLEASE PRINT CLEARLY IN ALL FIELDS

Patient Name: _____
Practice Name: _____
Referring Doctor: _____
Office Address: _____
City: _____ Zip Code: _____
Phone Number: _____
Payment Responsibility: ☐ Doctor ☐ Patient(Fee$____)

FORMAT OPTIONS(MUST CHECK)

Images Printed (1mm Slices) – ☐

Burn to CD – ☐ Pdf ☐ Jpeg ☐ DICOM
☐ Interactive Viewer- Measurements aren't needed ☐

Email- ☐ Pdf ☐ Jpeg ☐ DICOM
☐ Interactive Viewer- Measurements aren't needed ☐
Email Address: _____

Dental Cone Beam CT Procedure(Must Check)

Implant Survey
Maxillary Arch
☐ Tooth #_____
☐ Entire Arch
Mandibular Arch
☐ Tooth #_____
☐ Entire Arch

Teeth Will Be Separated Unless Marked
☐ Teeth In Occlusion
☐ Patient Wears Stent
☐ Dual Scan Protocol (Included In Fee)

☐ **Impacted Tooth Survey**
Tooth #: _____

TMJ Survey
☐ Closed Only(Transaxial Included)
☐ Open/Closed
☐ At Rest

☐ **Pathology Survey**
Tooth # _____

☐ Panorex
☐ Orthodontic Scan (Ceph+Pano)
☐ Radiologist Report
Additional Fee $125

☐ Intraoral scan
Additional Fee - $125

RIGHT								LEFT							
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

PHYSICIAN ID: _____ AUTHORIZED SIGNATURE: _____

3rd Party Company(Lab) Email: _____

Special Instructions: _____

Patient Only

Please Print Clearly

Patient Name: _____ Date of Birth: _____ Age: _____
Home Address: _____ Male/Female
City _____ State: _____ Zipcode: _____
Phone Number: _____ Cell Number: _____
Parent/Guardian: _____ **Female Patients** – Are you Pregnant? Yes/No

Signature: _____ Date: _____

Tech Only

Van Number: _____ Procedure: _____ Next Appt W/Dr.: _____ Technician: _____
Scan Charge: $_____ Additional Charges: $_____ Total: $_____
Delivered: Prints: _____ CD: _____ Email: _____
Doctor or Patient Doctor or Patient

HIPPA COMPLIANT **FORM REVISED: 6/1/2024**