

www.cdental.com | Send referrals to referral@cdental.com

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|---|--|--|--|--|--|
| <input type="checkbox"/> SAN FRANCISCO
450 Sutter Street, #1542
P 415-421-1389 | <input type="checkbox"/> SAN MATEO
424 N. San Mateo Dr. #100
P 650-685-8097 | <input type="checkbox"/> SAN RAFAEL
1050 Northgate Drive, #445
P 415-472-1323 | <input type="checkbox"/> PLEASANTON
5776 Stoneridge Mall Rd #180
P 925-846-9291 | <input type="checkbox"/> SAN JOSE
5150 Graves Ave., #10A
P 408-446-9729 | <input type="checkbox"/> OAKLAND
170 Santa Clara Ave, #101
P 510-368-7236 |
| <input type="checkbox"/> SF - WEST PORTAL
362 West Portal Ave.
P 415-753-8701 | <input type="checkbox"/> MENLO PARK
695 Oak Grove Ave. #330
P 650-323-0204 | <input type="checkbox"/> MOUNTAIN VIEW
505 South Dr. #7
P 650-965-1320 | <input type="checkbox"/> WALNUT CREEK
1900 Olympic Blvd #201
P 925-935-0500 | <input type="checkbox"/> MOBILE IMAGING VAN
P 925- 935-0500 | |

Patient	DOB	CASE DELIVERY (paperless by default)
Patient Email	Referral Date	Paperless Options: <input type="checkbox"/> Box.com (email) <input type="checkbox"/> CD <input type="checkbox"/> OD3D Viewer <input type="checkbox"/> DICOM Only <input type="checkbox"/> 24hr Rush + \$50
Patient Phone	Next Appt	
Collaborating Doctor Email		Hard Copy Prints: <input type="checkbox"/> Paper (addtl fee applies to paying party)

Indicate Areas of Interest:

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

2D DIGITAL IMAGING			
<input type="checkbox"/> Panograph <input type="checkbox"/> Full Mouth X-Ray <input type="checkbox"/> 20 Films <input type="checkbox"/> 27 Films <input type="checkbox"/> VBWS <input type="checkbox"/> HBWS <input type="checkbox"/> Grids <input type="checkbox"/> Paralleling Survey <input type="checkbox"/> Single Area(s) (indicate tooth #s) <input type="checkbox"/> Hand/Wrist Film	<input type="checkbox"/> Bitewings Survey <input type="checkbox"/> Horizontal Films: <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> Vertical Films: <input type="checkbox"/> 6 <input type="checkbox"/> 4 <input type="checkbox"/> Grids <input type="checkbox"/> All Around <input type="checkbox"/> Occlusals <input type="checkbox"/> Mandible <input type="checkbox"/> Maxilla <input type="checkbox"/> Topographical <input type="checkbox"/> Photography	<input type="checkbox"/> Cephalometric <input type="checkbox"/> Lateral <input type="checkbox"/> PA <input type="checkbox"/> AP <input type="checkbox"/> Cephalometric Tracing <input type="checkbox"/> Steiner Tweed Wits (default) <input type="checkbox"/> Other _____	<input type="checkbox"/> Beg <input type="checkbox"/> Progress <input type="checkbox"/> Final <input type="checkbox"/> Full 2D Orthodontic Survey <i>FMX, Pan, Ceph, Tracing, Photos</i> <input type="checkbox"/> Limited 2D Ortho Survey <i>Pan, Ceph, Tracing, Photos</i> <input type="checkbox"/> Custom Orthodontic Survey

3D INTRAORAL IMAGING			
<input type="checkbox"/> Invisalign <input type="checkbox"/> Invisalign Refinement	<input type="checkbox"/> Clear Correct <input type="checkbox"/> Vivera Retainer	<input type="checkbox"/> iRecord (standard digital model) <input type="checkbox"/> iCast (Ortho base digital model)	<input type="checkbox"/> STL File Delivery <input type="checkbox"/> By email <input type="checkbox"/> To laboratory Lab Email _____

**Dr must remove arch wire for Vivera Retainer scan*

3D CBCT IMAGING			
CHOOSE SCAN DIMENSION <input type="checkbox"/> FOCUS <i>(1-3 adjacent teeth - not for guided surgery)</i> <input type="checkbox"/> SMALL <input type="checkbox"/> Mandible <input type="checkbox"/> Maxilla <input type="checkbox"/> Both Arches <input type="checkbox"/> LARGE (15x15 cm)	CHOOSE SURVEY <input type="checkbox"/> Endodontic <input type="checkbox"/> General Dental Evaluation <input type="checkbox"/> Sinus <input type="checkbox"/> Facial Pain <input type="checkbox"/> Impactions (indicate tooth #s) <input type="checkbox"/> Implant	<input type="checkbox"/> CBCT FMX & Panograph <input type="checkbox"/> TMJ <input type="checkbox"/> Open/Closed <input type="checkbox"/> Closed <input type="checkbox"/> w/Appliance <input type="checkbox"/> Sleep Apnea (OSAS) <input type="checkbox"/> w/Appliance <input type="checkbox"/> Supine Scan (@ Menlo Park office only) <input type="checkbox"/> Post-Op Scan *Within 4 mo, same AOI, 3D Viewer Only <input type="checkbox"/> 3D Photos	<input type="checkbox"/> Beg <input type="checkbox"/> Progress <input type="checkbox"/> Final <input type="checkbox"/> Add 3D intraoral models <input type="checkbox"/> Basic 3D Orthodontic <i>3D FMX, Pan, Ceph, Tracing, 2D Photos</i> <input type="checkbox"/> Standard 3D Orthodontic <input type="checkbox"/> Dolphin 3D Ortho Survey <input type="checkbox"/> 3D Orthognathic <input type="checkbox"/> Basic <input type="checkbox"/> Standard <input type="checkbox"/> Advanced* <i>*Includes intraoral scan & surgical plan</i>

Full Mouth Reconstruction (Large & small CBCT, intraoral scan & 3D photos) Intraoral scan with & w/o partial to establish vertical Wax rim to establish vertical

GUIDED SURGERY		
1. Indicate Planning Option <input type="checkbox"/> No Guide - Software Conversion Only <input type="checkbox"/> Guided Surgery 2. Indicate Planning Program <input type="checkbox"/> In2Guide <input type="checkbox"/> Implant	3. In2Guide ONLY - Choose Virtual Design Option (select one) <input type="checkbox"/> No Wax-Up - 3D Intraoral Scan & Merge to CBCT <input type="checkbox"/> No Wax-Up - Immediate Extraction <input type="checkbox"/> No Wax-Up - 3D Intraoral Scan with & w/o Partial/Temporary <input type="checkbox"/> Virtual Wax-Up - CBCT & 3D Intraoral Scan (indicate tooth #s) <input type="checkbox"/> Dual Scan - Radiographic Guide or Marked Denture	4. Virtual Wax-Up Tooth #s _____ <input type="checkbox"/> Authorize virtual wax-up order Checking this box authorizes C-Dental to order virtual design services from OnDemand3D. These services are rendered and billed by Ondemand3D (Irvine, CA). <i>*Addtl fees apply for surgical guides</i>

CBCT Radiology Reports: <input type="checkbox"/> NDI Basic (does not apply to TMJ or both arch CBCT) <input type="checkbox"/> NDI Analytical <input type="checkbox"/> BeamReaders <input type="checkbox"/> UCLA <input type="checkbox"/> C3DR (2-3 day turnaround)	Doctor Signature: CA State Law requires a signature from the referring physician.
SPECIAL INSTRUCTIONS <input type="checkbox"/> Bill Doctor <input type="checkbox"/> Patient Pays <input type="checkbox"/> Need 3D Software Assistance	

C-Dental X-Ray Locations

San Francisco - Downtown

450 Sutter Street, Suite 1542
San Francisco, CA 94108
415-421-1389
415-421-0146 Fax

San Francisco - West Portal

362 West Portal Avenue
San Francisco, CA 94127
415-753-8701
415-753-8703 Fax

San Mateo

424 N. San Mateo Drive, Suite 100
San Mateo, CA 94401
650-685-8097
650-685-8099 Fax

Oakland

170 Santa Clara Ave, Ste 101
Oakland CA, 94610
510-368-7236
510-280-8440 Fax

San Rafael

1050 Northgate Drive, Suite 445
San Rafael, CA 94903
415-472-1323
415-472-1364 Fax

Menlo Park

695 Oak Grove Avenue, Suite 330
Menlo Park, CA 94025
650-323-0204
650-329-0265 Fax

Mountain View

505 South Drive, Suite 7
Mountain View, CA 94040
650-965-1320
650-428-0505 Fax

BAY AREA MOBILE IMAGING VAN

(925) 935-0500

Pleasanton

5776 Stoneridge Mall Rd, #180
Pleasanton, CA 94588
925-846-9291
925-846-9260 Fax

Walnut Creek

1900 Olympic Blvd., Suite 201
Walnut Creek, CA 94596
925-935-0500
925-935-0533 Fax

San Jose

5150 Graves Avenue, Suite 10A
San Jose, CA 95129
408-446-9729
408-446-9799 Fax

Billing & Insurance Policies

PAYMENT

C-Dental X-Ray and McCormack Dental Imaging, ask for payment at the time of service. Payment can be made by Cash, Credit Card (Visa, Mastercard, AMEX or Discover), Check, or CareCredit financing (6 month financing for \$200+ orders).

DENTAL INSURANCE

C-Dental/MDI is not in-network with Dental insurance carriers, however, C-Dental/MDI may assist patients with the filing of insurance claims as a courtesy. C-Dental/MDI will fill out an insurance claim with the correct procedure codes. All insurance payments will be made to the patient directly from the insurance carrier if a reimbursement is due. It is the responsibility of the patient to follow-up with their insurance company. Please bring the following dental insurance information for us to assist you:

- Dental insurance provider name
- Group Number
- Subscriber ID number or last 4 of social security number
- Claims address (Usually a P.O. Box listed on the back of your insurance card)

MEDICAL INSURANCE

A referral signed by a DDS/MD is required. C-Dental/MDI may assist patients with filling out medical health insurance claims for patients receiving medical treatment from a Dental office. Your dentist must provide you with a medical diagnosis code to be entered on your claim form. It is the responsibility of the patient to follow-up with their insurance company. Medical procedures C-Dental/MDI provides imaging for include but are not limited to Restricted Airway, TMJ, and Oral Surgery.

Patients must call their imaging center location of choice to make an appointment. Referral is required at the time of the appointment. Please remove jewelry prior to your appointment.

San Francisco | SF West Portal | San Mateo | San Rafael | Menlo Park | Mountain View | Pleasanton | Walnut Creek | San Jose | Oakland
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