

DENTAL IMAGING REFERRAL

www.cdental.com | info@cdental.com

SUBMIT REFERRALS TO referral@cdental.com

SAN FRANCISCO 415-421-1389
SF - WEST PORTAL 415-753-8701
MENLO PARK 650-323-0204
MOUNTAIN VIEW 650-965-1320
SAN RAFAEL 415-472-1323

PLEASANTON 925-846-9291
CAMPBELL 408-446-9729
SAN MATEO 650-685-8097
WALNUT CREEK 925-935-0500
OAKLAND 510-368-7236



PATIENT INFORMATION

PATIENT

DOB

PAYMENT RESPONSIBILITY

☐ Patient ☐ Bill Doctor

PHONE #

PATIENT EMAIL

PARENT/GUARDIAN

REFERRING DOCTOR

REFERRAL DATE

DOCTOR EMAIL *Cases will be sent to this email*

SEND DIGITAL COPY TO COLLABORATING DOCTOR(S) or LAB

CASE DELIVERY OPTIONS: ☐ Disc ☐ Email ☐ DICOM Only ☐ DICOM + Viewer ☐ JPEGs, DICOM + Viewer ☐ Paper Prints*

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

3D CBCT IMAGING

STEP 1 | CHOOSE SCAN DIMENSION

☐ MAXILLA ☐ BOTH ARCHES ☐ ONE QUADRANT
☐ MANDIBLE ☐ BOTH ARCHES, TMJ & AIRWAY *(1-3 adjacent teeth)*

AREA(S) OF INTEREST: Tooth # _____

STEP 2 | CHOOSE SURVEY

☐ ENDODONTIC
☐ IMPLANT ☐ Post-Op *(w/in 6 months - same AOI)*
☐ IMPACTIONS/3rd MOLARS
☐ PATHOLOGY
☐ CBCT FMX & PANOGRAPH
☐ SLEEP APNEA (OSAS) ☐ Add Sinus
☐ TMJ: ☐ Open ☐ Closed ☐ + Appliance ☐ Add 3D Movie
☐ ORTHOGNATHIC ☐ Add 3D Movie ☐ Add Digital Surgical Cuts + IOS

3D ORTHODONTIC

☐ **BASIC 3D ORTHODONTIC** ☐ **STANDARD 3D ORTHODONTIC**
FMX, Panograph, Lateral Ceph, Tracing, Photography
3D Basic Ortho + TMJ, Airway, Occlusals, Tooth Cross-Sections
☐ Add IOS ☐ Add 3D Movie ☐ Add IOS

2D ORTHODONTIC

☐ **2D LIMITED SURVEY** ☐ **2D FULL SURVEY**
Panograph, Lateral Cephalometric, Tracing, Photography
FMX, Panograph, Lateral Ceph, Tracing, Photography
☐ Add IOS ☐ Add IOS

3D INTRAORAL SCANS (IOS)

PRINTED MODELS

☐ 3D INTRAORAL SCAN (STL Files) ☐ Standard Definition
☐ Invisalign ☐ ClearCorrect ☐ Vivera ☐ High Definition
☐ REFINEMENT SCAN ☐ HARD MODEL SCAN ☐ Steliolithic Bone Model

SPECIAL INSTRUCTIONS

☐ **24hr RUSH CASE** - Addtl Fee Applies

GUIDED SURGERY

☐ **IMPLANT | Guided Surgery** ☐ **Doctor Providing IOS**
Upload Form On Our Website
IMPLANT/KIT TYPE *Indicate manufacturer*

VIRTUAL DESIGN OPTION

☐ **No Wax-Up** | IOS + Merge to CBCT
☐ **No Wax-Up** | Immediate Extraction
☐ **No Wax-Up** | IOS with & w/o Partial/Temporary
☐ **Virtual Wax-Up** | CBCT + IOS
☐ **Wax-Up Tooth #s** _____
Checking this box authorizes C-Dental to complete virtual design services.
☐ **Dual Scan** | Radiographic Guide or Marked Denture
☐ **Full Mouth Reconstruction**
☐ IOS with & w/o partial to est. vertical ☐ Wax rim to est. vertical

2D DIGITAL X-RAYS

☐ FULL MOUTH X-RAY ☐ 27 ☐ 20
☐ 8 ANT + 4 BW ☐ PARALLELING SURVEY
☐ BITEWINGS ☐ 2 ☐ 4 ☐ 6 ☐ Horizontal ☐ Vertical
☐ 8 ANTERIORS ☐ 4 ANTERIORS
☐ SINGLE AREA(S) Tooth # _____
☐ OCCLUSAL ☐ Maxilla ☐ Mandible ☐ Both ☐ HAND/WRIST
☐ PANOGRAPH ☐ PHOTOGRAPHY
☐ CEPHALOMETRIC ☐ Lateral ☐ PA ☐ AP
☐ ADD TRACING *(Steiner Tweed Witts)* ☐ Other _____

RADIOLOGY REPORTS

☐ 2D X-RAY REPORT
☐ PATHOLOGY REPORT ☐ ANALYTICAL REPORT
Does not apply to TMJ or Both Arch CBCT

DOCTOR SIGNATURE

CA State Law requires a signature from the referring physician.

FEES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED; UNLESS BILL DOCTOR IS MARKED ABOVE. VISA MC, DISCOVER, AMEX, CARE CREDIT, CASH OR CHECKS ACCEPTED.
PLEASE REMOVE ALL JEWELRY PRIOR TO APPOINTMENT. A REFERRAL IS REQUIRED AT THE TIME OF THE APPOINTMENT.

C-DENTAL X-RAY LOCATIONS

SAN FRANCISCO

450 Sutter St, #1542
San Francisco, CA 94108
415-421-1389

MENLO PARK

695 Oak Grove Ave #330
Menlo Park, CA 94025
650-323-0204

PLEASANTON

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

SF - WEST PORTAL

362 West Portal Ave
San Francisco, CA 94127
415-753-8701

MOUNTAIN VIEW

505 South Dr, #7
Mountain View, CA 94040
650-965-1320

OAKLAND

170 Santa Clara Ave, #101
Oakland CA, 94610
510-368-7236

SAN RAFAEL

750 Las Gallinas Ave #102
San Rafael, CA 94903
415-472-1323

CAMPBELL

281 E. Hamilton Ave, #9
Campbell, CA 95008
408-446-9729

WALNUT CREEK

1900 Olympic Blvd, #201
Walnut Creek, CA 94596
925-935-0500

SAN MATEO

424 N San Mateo Dr, #100
San Mateo, CA 94401
650-685-8097

MAIN EMAIL TO SUBMIT REFERRALS FOR ALL LOCATIONS

referral@cdental.com

MAIN FAX FOR ALL LOCATIONS

415-421-0146

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. Upon request, C-Dental/MDI will fill out an insurance claim with the correct procedure codes for the patient. 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 submit the claim and follow-up with their insurance company.

C-Dental X-Ray does not guarantee that insurance carriers will reimburse imaging costs. Patients are encouraged to check with their insurance provider regarding coverage and eligibility before their appointment.

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. FEES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED; UNLESS BILL DOCTOR IS MARKED. VISA MC, DISCOVER, AMEX, CARE CREDIT, CASH OR CHECKS ACCEPTED. PLEASE REMOVE ALL JEWELRY PRIOR TO APPOINTMENT. A REFERRAL IS REQUIRED AT THE TIME OF THE APPOINTMENT.

**Additional fee applies for printed cases*



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