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

C-DENTAL X-RAY

PATIENT INFORMATION

PATIENT _____ **DOB** _____

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

PAYMENT RESPONSIBILITY

◯ **Patient** ◯ **Bill Doctor**

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 *(1-3 adjacent teeth)*
◯ MANDIBLE ◯ BOTH ARCHES, TMJ & AIRWAY

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**
FMX, Panograph, Lateral Ceph, Tracing, Photography
◯ Add IOS

◯ **STANDARD 3D ORTHODONTIC**
3D Basic Ortho + TMJ, Airway, Occlusals, Tooth Cross-Sections
◯ Add 3D Movie ◯ Add IOS

2D ORTHODONTIC

◯ **2D LIMITED SURVEY**
Panograph, Lateral Cephalometric, Tracing, Photography
◯ Add IOS

◯ **2D FULL SURVEY**
FMX, Panograph, Lateral Ceph, Tracing, Photography
◯ Add IOS

3D INTRAORAL SCANS (IOS)

◯ 3D INTRAORAL SCAN (STL Files) ◯ PRINTED MODELS
◯ Invisalign ◯ ClearCorrect ◯ Vivera ◯ ABO BASE
◯ REFINEMENT SCAN ◯ HARD MODEL SCAN

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

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

SPECIAL INSTRUCTIONS

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

_____
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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