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- |   |  |  |  |  |  |
|---|--|--|--|--|--|
| <input type="checkbox"/> <b>SAN FRANCISCO</b><br>450 Sutter Street, #1542<br>P 415-421-1389 | <input type="checkbox"/> <b>SAN MATEO</b><br>424 N. San Mateo Dr. #100<br>P 650-685-8097 | <input type="checkbox"/> <b>SAN RAFAEL</b><br>1050 Northgate Drive, #445<br>P 415-472-1323 | <input type="checkbox"/> <b>PLEASANTON</b><br>1475 Cedarwood Ln. #D<br>P 925-846-9291    | <input type="checkbox"/> <b>SAN JOSE</b><br>5150 Graves Ave., #10A<br>P 408-446-9729 | <input type="checkbox"/> <b>OAKLAND</b><br>170 Santa Clara Ave, #101<br>P 510-368-7236 |
| <input type="checkbox"/> <b>SF - WEST PORTAL</b><br>362 West Portal Ave.<br>P 415-753-8701  | <input type="checkbox"/> <b>MENLO PARK</b><br>695 Oak Grove Ave. #330<br>P 650-323-0204  | <input type="checkbox"/> <b>MOUNTAIN VIEW</b><br>505 South Dr. #7<br>P 650-965-1320        | <input type="checkbox"/> <b>WALNUT CREEK</b><br>1900 Olympic Blvd #201<br>P 925-935-0500 | <input type="checkbox"/> <b>MOBILE IMAGING VAN</b><br>P 925- 935-0500                |  |

|                                   |                      |  |
|-----------------------------------|----------------------|--|
| <b>Patient</b>                    | <b>DOB</b>           | <b>CASE DELIVERY (paperless by default)</b>  |
| <b>Patient Email</b>              | <b>Referral Date</b> | <b>Paperless Options:</b> <input type="checkbox"/> Box.com (email) <input type="checkbox"/> CD                     |
| <b>Patient Phone</b>              | <b>Next Appt</b>     | <input type="checkbox"/> OD3D Viewer <input type="checkbox"/> DICOM Only <input type="checkbox"/> 24hr Rush + \$50 |
| <b>Collaborating Doctor Email</b> |                      | <b>Hard Copy Prints:</b> <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"/> <b>Panograph</b><br><input type="checkbox"/> <b>Full Mouth X-Ray</b><br><input type="checkbox"/> 20 Films <input type="checkbox"/> 27 Films <input type="checkbox"/> VBWS<br><input type="checkbox"/> HBWS <input type="checkbox"/> Grids<br><input type="checkbox"/> <b>Paralleling Survey</b><br><input type="checkbox"/> <b>Single Area(s)</b> (indicate tooth #s)<br><input type="checkbox"/> <b>Hand/Wrist Film</b> | <input type="checkbox"/> <b>Bitewings Survey</b><br><input type="checkbox"/> Horizontal Films: <input type="checkbox"/> 4 <input type="checkbox"/> 2<br><input type="checkbox"/> Vertical Films: <input type="checkbox"/> 6 <input type="checkbox"/> 4<br><input type="checkbox"/> Grids <input type="checkbox"/> All Around<br><input type="checkbox"/> <b>Occlusals</b><br><input type="checkbox"/> Mandible <input type="checkbox"/> Maxilla <input type="checkbox"/> Topographical<br><input type="checkbox"/> <b>Photography</b> | <input type="checkbox"/> <b>Cephalometric</b><br><input type="checkbox"/> Lateral <input type="checkbox"/> PA <input type="checkbox"/> AP<br><input type="checkbox"/> <b>Cephalometric Tracing</b><br><input type="checkbox"/> Steiner Tweed Wits (default)<br><input type="checkbox"/> Other _____ | <input type="checkbox"/> Beg <input type="checkbox"/> Progress <input type="checkbox"/> Final<br><input type="checkbox"/> <b>Full 2D Orthodontic Survey</b><br><i>FMX, Pan, Ceph, Tracing, Photos</i><br><input type="checkbox"/> <b>Limited 2D Ortho Survey</b><br><i>Pan, Ceph, Tracing, Photos</i><br><input type="checkbox"/> <b>Custom Orthodontic Survey</b> |

| 3D INTRAORAL IMAGING   |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> <b>Invisalign</b><br><input type="checkbox"/> <b>Invisalign Refinement</b><br><i>*Dr must remove arch wire for Vivera Retainer scan</i> | <input type="checkbox"/> <b>Clear Correct</b><br><input type="checkbox"/> <b>Vivera Retainer</b> | <input type="checkbox"/> <b>iRecord</b> (standard digital model)<br><input type="checkbox"/> <b>iCast</b> (Ortho base digital model) | <input type="checkbox"/> <b>STL File Delivery</b><br><input type="checkbox"/> By email <input type="checkbox"/> To laboratory<br>Lab Email _____ |

| 3D CBCT IMAGING  |  |   |   |
|--|--|---|---|
| <b>CHOOSE SCAN DIMENSION</b>   | <b>CHOOSE SURVEY</b>   |   |   |
| <input type="checkbox"/> <b>FOCUS</b><br><i>(1-3 adjacent teeth - not for guided surgery)</i><br><input type="checkbox"/> <b>SMALL</b><br><input type="checkbox"/> Mandible <input type="checkbox"/> Maxilla<br><input type="checkbox"/> Both Arches<br><input type="checkbox"/> <b>LARGE</b> (15x15 cm) | <input type="checkbox"/> <b>Endodontic</b><br><input type="checkbox"/> <b>General Dental Evaluation</b><br><input type="checkbox"/> <b>Sinus</b><br><input type="checkbox"/> <b>Facial Pain</b><br><input type="checkbox"/> <b>Impactions</b> (indicate tooth #s)<br><input type="checkbox"/> <b>Implant</b> | <input type="checkbox"/> <b>CBCT FMX</b> <input type="checkbox"/> <b>CBCT Panograph &amp; BWs</b><br><input type="checkbox"/> <b>TMJ</b><br><input type="checkbox"/> Open/Closed <input type="checkbox"/> Closed <input type="checkbox"/> w/Appliance<br><input type="checkbox"/> <b>Sleep Apnea (OSAS)</b><br><input type="checkbox"/> w/Appliance <input type="checkbox"/> Supine Scan (@ Menlo Park office only)<br><input type="checkbox"/> <b>Impactions</b> (indicate tooth #s) | <input type="checkbox"/> <b>3D Orthodontic</b><br><input type="checkbox"/> Beg <input type="checkbox"/> Progress <input type="checkbox"/> Final<br><input type="checkbox"/> Add 3D Intraoral Models<br><input type="checkbox"/> <b>3D Orthognathic</b><br><input type="checkbox"/> Basic <input type="checkbox"/> Advanced*<br><i>*Includes intraoral scan &amp; surgical plan</i><br><input type="checkbox"/> <b>Post-Op Scan</b><br><i>*Within 4 mo of initial scan, same AOI</i> |
| <input type="checkbox"/> <b>Full Mouth Reconstruction</b> (Large & small CBCT, intraoral scan & 3D photos) <input type="checkbox"/> Intraoral scan with & w/o partial to establish vertical <input type="checkbox"/> Wax rim to establish vertical   |  |   |   |

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

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

## 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

1475 Cedarwood Lane, Suite D  
Pleasanton, CA 94566  
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

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## 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

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.*

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