Thomas H George DDS, PC 3D Referral Form

NOTE TO PATIENTS PAYMENT IS DUE AT TIME OF SERVICE. Cost $249/Arch We Accept Cash, Check, C/C or CareCredit

Appointment Phone #: 815-937-4455

PATIENT NAME ______________________ APPT. DATE __________

D.O.B ______________________ APPT. TIME __________

PHONE# ______________ *(Appointments can be made by the dentist or by patient)*

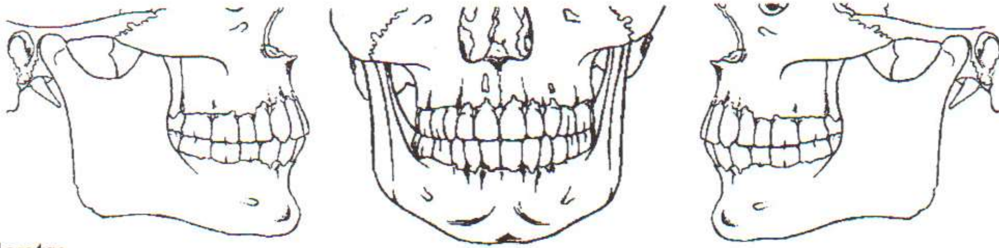
3-D CBCT Volumetric Imaging: ❑ **Expedited Service (within 24 hrs.)**

❑ Implants ❑ Dental Impaction ❑ Airway Assessment ❑ Sinus Exam

❑ TMJ Exam ❑ Oral Pathology ❑ Endodontics ❑ Ortho

❑ Full Radiologist Reports $80 ❑ Other __________

Please circle the Region of Interest (ROI)



Implants:

Implant area: Mandible__________ Maxilla__________ Both __________

Is your patient coming with a radiographic template? Yes ❑ No ❑

(Indicate teeth or area 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

Dr. Name:	
Practice Name:	
Address:	
City, State, Zip:	
Telephone Number:	
Fax Number:	
Email Address:	
Signature and Date: