ENDODONTIC SPECIALTY & IMAGING CENTER

9353 Fairway View Place, Suite 210
Rancho Cucamonga, CA 91730

Office Hours: M – F 8:30am – 4:00pm
(909) 243-7575 Appointment Required

Prescription for Dental Imaging Service

Please bring this referral slip with you.

Patient: _____ **Appt. Date**: _____

Date of Birth: _____ **Appt. Time**: _____

3-D CBCT Volumetric Imaging

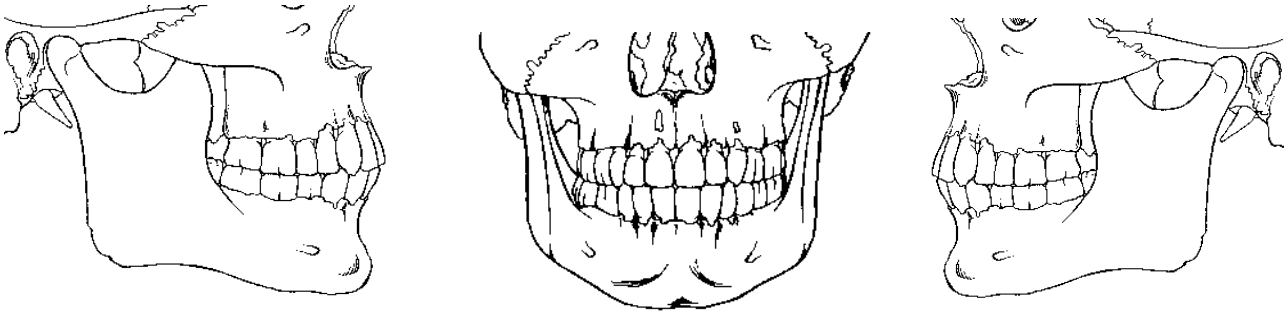
This service includes one CBCT imaging session and one CD.
Payment is due when services are rendered
Fee: $ 195.00 Additional Copies: CD $25.00 Hard Copy $50.00

Reasons for Scan: Please check

Implants ☐ Oral Pathology ☐ Other ☐

Endodontics ☐ Dental Impaction ☐

Please circle the Region of Interest



Patient Arch Form U_____ V_____ ⊔_____

By signing below, I request Endodontic Specialty & Imaging Center and its associates to acquire, and review the images and have obtained authorization from the patient for these procedures.

Print Name of Doctor _____ Signature _____

Address _____

Telephone Number _____ Date _____

Note: Under California Law, services cannot be rendered without a fully completed and signed prescription.

Print Submit Reset