Dental Lab

www.tcdentallab.com

1000 NE 122nd ave, Portland OR 97230
Phone: (800) 926-5412 Fax: (503) 254-1957

Refering Doctor:_____

Office name:_____

Paitent Name:_____

Phnone number:_____

Date of birth:: _____/_____/_____

Appt Date:_____

Appt TIme:_____

Mail DVD to:_____

_____

Please check purpose for Scan:

☐ CT Planning
- ☐ TC to plan Case
- ☐ Doctor to plan Case

Scan Appliance Provided? ☐ yes ☐ no

Scan Appliances are required if patient is receiving 4+ implants, or 50% of teeth include metal-based crowns, or patient is edentulous. Scan appliance design must be TC fabricated or approved

☐ **Implant**

☐ **Dental Impaction**

☐ **Sinus Exam**

☐ **Endodontics**

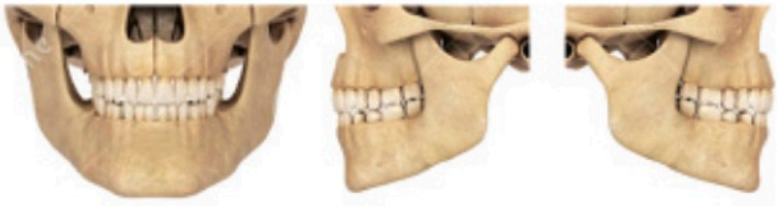
☐ **Jaw Fracture**

☐ **Pathology**

☐ **Other:** _____

Radiologist report recommended.
☐ Accept ☐ Decline (Additional fee will be applied)

Circle area of interest:



Full Scan **Quadrant Scan**

Payment options: ☐ **doctor pays** ☐ **patient pays**

☐ **Add to doctor's account**

☐ **Check Enclosed - Check # _____ (deposit date ___/___/_____ office use only)**

Visa / MasterCard / Amex

Card Number _____-_____-_____-_____ **(authorization # _____ office use only)**

Doctor's Signature: _____ License # _____

Call (800) 926-5412 to schedule appointment