



Dental Lab

www.tcdentallab.com

1000 NE 122nd ave, Portland OR 97230

Phone: (800) 926-5412 Fax: (503) 254-1957

Referring doctor: _____

Appointment date: _____

Office name: _____

Appointment time: _____

Patient name: _____

Mail DVD to: _____

Phone number: _____

Date of birth: ____ / ____ / ____

Please check purpose for Scan:

CT Planning

TC to plan Case

Doctor to plan Case

Scan Appliance Provided? Scan Appliances are required if patient

yes no

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

Endodontics

Dental Impaction

Jaw Fracture

Sinus Exam

Pathology

Radiologist report recommended.

Other: _____

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