

**Doctors Information**

Doctors Name: \_\_\_\_\_  
 Specialty: \_\_\_\_\_  
 Office Contact Name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Fax Number: \_\_\_\_\_  
 Office Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_

**3D Imaging Modeling Information**

Arch:  Mandible \$350  Maxilla \$350  Both \$600

Model Ship to Name: \_\_\_\_\_

Model Ship to Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**Patients Information**

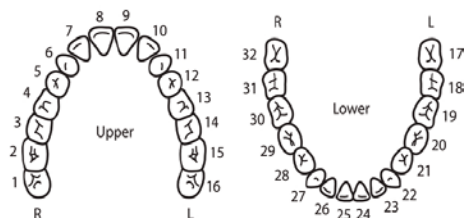
Patient Name: \_\_\_\_\_

Case Timing: \_\_\_\_\_

(Standard turnaround time is 2 business days from the receipt of CT scan. Please call if you need faster turnaround.)

Case Description/Special Instructions: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please indicate area of interest on the illustrations below:



Dental Lab Name: \_\_\_\_\_

Dental Lab Contact/Phone: \_\_\_\_\_

Scanning Facility Name: \_\_\_\_\_

Scanning Facility Contact/Phone: \_\_\_\_\_

**Billing Information**

Payment by:  Visa  Master Card  Discover  American Express

Name on Card: \_\_\_\_\_

Card Number: \_\_\_\_\_ CID No: \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_

Exp Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Total
\$

165 W 46 Street, Suite 611  
 New York, N.Y. 10036

2350 Ocean Ave  
 Brooklyn, N.Y. 11229



Email: [dentalcatscan@3dimagingcenter.com](mailto:dentalcatscan@3dimagingcenter.com) , [eryca@3dimagingcenter.com](mailto:eryca@3dimagingcenter.com)

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