

Prescription for Dental C one Beam CT Imaging and Implant Guide Services

Instruction: Please fill this form out. (Fields with an * are mandatory)



Reliable Dental Laboratory

10610 Metric Dr. #191, Dallas Texas 75243

(972) 272-5511 • Fax: (214) 503-8686

WWW.rdlldental.com

Texas Reg #2827

Referring Doctor			
Last Name	First Name	Phone number:	
City:			
Office Address:	State	Zip:	E-mail:
Patient Identification			
Last Name	First Name	Date of Birth(mm/dd/yyyy)	
Office Address:			
City:	State	Zip:	Phone number:
Referring Doctors office must call lab to schedule appointment prior to sending patient for dental CBCT			
Please Provide the Following service			
Dental CBCT <input type="checkbox"/>	Implant Site Surgical Planning Imaging <input type="checkbox"/>	Implant Tooth Evaluation <input type="checkbox"/>	
Surgical Implant Guide <input type="checkbox"/>	Pathology Evaluation / Report <input type="checkbox"/>	Sinus Evaluation <input type="checkbox"/>	

Computer Guided Surgery Implant Planning Prescription

Implant Manufacturer _____

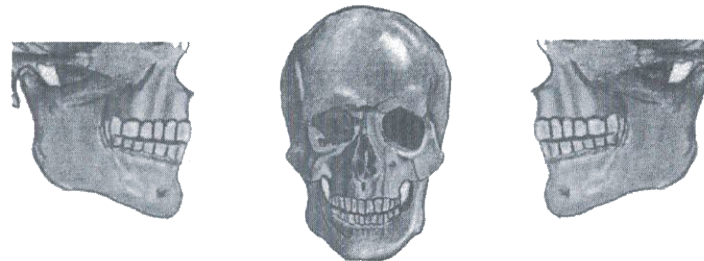
Specific name of manufacturer's implant to be planned _____

Implant Connection

☐ Internal ☐ External

Type of Guide:

- ☐ Tissue Guide (Flapless)
☐ Bone Guide (Flap)
☐ Tooth Supported Guide
☐ Model Based Guide



☐ Implant sites

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

Final Prosthetic Goal:

☐ Fixed ☐ Removable ☐ Cementable Restoration ☐ Screw Retained Restoration

☐ Immediate Load Provisional ☐ Anterior esthetic placement for soft tissue esthetics

Dr. Signature: _____ License No _____

CALL BEFORE STARTING	ENCLOSED
<input type="checkbox"/> Check here for Clinical advisor <input type="checkbox"/> Dr. Marcus Lastimado DMD, MAGD, MICOI <input type="checkbox"/> Check here for a technician	<input type="checkbox"/> Study Model <input type="checkbox"/> Impression(s) <input type="checkbox"/> Working Model <input type="checkbox"/> Radiographic guide / stent

Name (optional) _____

Notes

If you need to reschedule contact
Reliable Within 24 hours
to avoid a
\$50 Cancellation fee

The Statement balance is due and payable by the 30 Of the month following purchase. Accounts with an outstanding balance over 45 days will be subject to COD status.

if you have questions please contact hwilliams@rdldental.com

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