CT Scan Appliance Prescription

ALLSMAN DENTAL ARTS
212 E Crossroads Blvd. #159
Saratoga Springs, UT 84043
(801) 944-3420

1) Information

Doctor Name: _____ Phone: _____

Office Contact: _____ Fax: _____

Address: _____ Patient Identifier: _____

City/ State/ Zip: _____ Patient Appointment Date: _____

Email: _____

2) CT Scan Appliance Instructions (Complete a separate prescription form for each arch)

Please indicate arch: ☐ Mandible ☐ Maxilla

The following teeth are being replaced: _____

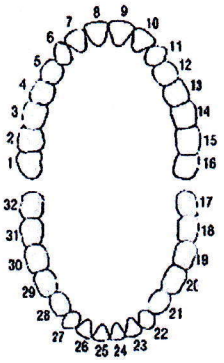
_____

Case Notes: _____

_____

Lab Notes: _____

_____



Indicate implant locations by selecting tooth number

3) Prescription Form Signature

I acknowledge responsibility for this patient's VIP dental implant position, treatment plan and surgical placement of dental implants.

_____ _____ _____

Doctor Name (Signature) Dental License Number Date

4) Contents Checklist

Please Complete CT Scan Appliance Contents Checklist *To ensure timely return of CT Scan Appliance, please include:*		
Standard case:	☐ Centric record	☐ Upper and lower diagnostic casts
Partially edentulous case:	☐ An impression with the provisional in place	☐ An impression with the provisional removed
Completely edentulous case:	☐ An acrylic duplication of the denture	
Partner Laboratory:	☐ Ship to BioHorizons Partner Laboratory (participating laboratories available on www.biohorizons.com)	

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