

Doctor's Name: _____ Office Name: _____
 Patient Name: _____ Return Date/Time: _____
 Dr's Preferred Contact: Secure E-Mail: _____ Phone: _____

Guide Type: Implant Placement Bone Reduction Fully Guided Pilot Guided
 CBCT Sent by: CD/USB Secure E-Mail DDX Other: _____
 CBCT Sent Date: _____
 Models: Impression/Model I/O Scan Dual Scan Diagnostic Model/Wax-up/Digital
 Model Sent Date: _____
 Preferred Implant System: _____

Rx_

- Grafting/Sinus Lift Planned
- Immediate Temp. Restoration

Implant Sites: (Please list tooth numbers here,
 or select teeth on diagram below)

