



Please complete this referral form and submit it with your stone model to:

e*Smile Dental Laboratory

347 E Barstow Ave. STE# 108 Fresno, CA 93710
tel: (559) 228-8608 • fax: (559) 777-4775
info@esmiledentallab.com • www.esmiledentallab.com



For predictable, reliable, and repeatable results



Doctor/Practice Information

- Doctor(s) _____
- Practice Name (if different) _____
- Office Address _____
- Office Phone / Fax _____
- Office Email _____

***Doctor:**

Please submit: (1) this referral, and (2) PVS impression or poured model.
Initial treatment proposal will be emailed within 5~7 days of receipt of CT scan + model.

Patient / Case Information

- Patient Name _____ Patient phone _____
- Preferred implant system _____ Guided surgical kit preference _____
- Surgery Date _____ Implant site(s) _____
- Restorative goal _____
- Additional comments/requests _____
- Is this denture case? (yes/no) _____
- These sites (if any) will be extracted _____

- Custom Healing Abutment with [Immediate Tissue Former ___] **or** [Immediate Temp Crown ___ / Shade ___]

I certify that all of the above information is correct. I agree to the credit card authorization and release of liability terms on the following or reverse page.

Doctor's Printed Name

Doctor's Signature

Date



Thank you for using e*Smile Dental Lab for your implant surgical guides. To help us best meet your needs and expectations, we request you complete and return this form. Thank you.

Doctor(s) _____

Practice Name (if different) _____

Practice Address _____

Additional Practice Address(es) _____

Office Phone _____ Fax _____

Office Email for scan delivery _____

Preferred implant systems _____ Guided surgical kit preference _____

Guide Coordinator: _____ Email _____

Please upload all cases through our web portal (Dropbox).

Surgical guide pricing:

Guide cost is \$325 + \$50 per additional implant site.

- Guide will be billed to your card prior to ordering.
- Stone model or Optical scan must be provided.
- Implant planning service only or uncompleted cases will be billed at \$200.

Cardholder Name _____ Visa Master AMEX Discover

Card Number _____ Expiration Date _____

Sec Code _____ Billing Zip Code _____

I certify that all of the above information is correct. I agree to the credit card authorization and release of liability terms on the following or reverse page.

Doctor's Printed Name

Doctor's Signature

Date





e*Smile Dental Laboratory

A PERFECT FIT THAT CREATES A PERFECT SMILE!
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Account Preferences And Release of Liability

Release of Liability

I acknowledge and accept that e*Smile Dental Lab and its employees will not participate in any treatment planning or patient care beyond providing the 3D or 2D scan(s) that I request, and possibly a surgical guide that I personally design and approve. I also acknowledge that any images and measurements provided by e*Smile Dental Lab and its employees are approximations from a single and unique perspective and may not be indicative of physiology as near as a fraction of a millimeter away. In addition, I accept that images and measurements provided by e*Smile Dental Lab and its employees are not in any way suggestive of treatment options. I am solely responsible for interpreting the 3D data provided and determining my own treatment plan. I have the option of sending each scan to a radiologist for review by checking Radiologist Review on my order form. If I decline this option by not checking the box, I assume full responsibility for reviewing and interpreting the scan as required by law. I acknowledge that e*Smile Dental Lab and its employees are not doctors or radiologists and are not qualified to offer clinical advice or identify pathology or other medical or dental conditions. I will consider any verbal or written statements made by e*Smile Dental Lab and its employees to be those of a layman. If I order a surgical guide through and/or with the assistance of e*Smile Dental Lab, I am solely responsible for determining the implant placement and approving that placement before the guide is manufactured. By ordering a guide, I acknowledge that I have sufficient training and experience to perform dental implant surgery manually. I acknowledge that a guide is a tool to assist me with a surgical procedure, but the guide does not replace my clinical judgment and operations. Guides are not guaranteed to be error free; I agree to always validate the guide before using it for any patient and I will not use a guide if it appears to be defective or deviate from my planning. I acknowledge that e*Smile Dental Lab, its owners and employees are not qualified to offer professional advice on or related to implant planning or guided surgery. I accept complete and sole responsibility for the fitness, quality, and performance of the guide and its use in surgery. I hereby release and discharge and agree to defend, indemnify and hold e*Smile Dental Lab and its officers, directors, shareholders and employees harmless from any liability arising from or related to any evaluation, diagnosis, or treatment of any patient in which a e*Smile Dental Lab generated scan and/or surgical guide was used. I understand this release and indemnity extends to any and all claims, demands, liabilities, causes of action, suits action, damages, costs and expenses, including all attorney fees, costs and expenses incurred as a result thereof, in connection or in any way related to my evaluation, diagnosis and treatment of my patient, including the services provided by e*Smile Dental Lab in connection there with, whether malpractice-related or not.

Credit Card Authorization

I hereby authorize e*Smile Dental Lab to charge my Visa, MasterCard, American Express or Discover credit card for each patient that I or my office staff refers for scanning services, when Bill Scan to Doctor is indicated. I understand that the charges will be done daily at the time of service. I may revoke this arrangement by so notifying e*Smile Dental Lab in writing, and the revocation will be effective upon the receipt of my notice by e*Smile Dental Lab. Any existing balance on my account at the time of this authorization will be charged to my credit card number as shown above. I understand that I may change the specific credit card at any time. If I do change the credit card, this form automatically authorizes e*Smile Dental Lab to charge the new card.



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