

**Dr. Frederick Li** D.M.D., F.I.C.O.I.

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## ***3d imaging Referral Form***

[info@DrFrederickLi.com](mailto:info@DrFrederickLi.com) or fax to 1-866-404-5091

Date \_\_\_\_\_

From: \_\_\_\_\_

To: **Frederick Li, DMD**

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Patient Name: \_\_\_\_\_ Insurance: Y/N

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

Scan size: (please circle)

Small field (single tooth non implant)

\$110.00

Large field (required for implant treatment planning)

\$220.00

\$340.00 (read by radiologist/recommended)

- The responsibility of reading the scan is the referring dentist's unless the scan is read by an oral radiologist.

Site: # \_\_\_\_\_

Reason for referral:

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Printout Y/N (all scans will be available for download or usb key)