Treatment Planning & Consultation Services Order Form

***** Please complete form and fax to (416) 962-MFAC (6322) *****

Patient Name: ______________________________

Implant Surgeon: ______________________ Best Time for Web-Meeting: ______________________

Office Phone: ______________________ Mobile Phone: ______________________

E-mail: ______________________________

Treatment Planning Software: SimPlant ❑ OneShot ❑ Planner ❑ Pro ❑ Master

Treatment Planning Service	Number of Implants	Additional Consultation Minutes	TOTAL
Please contact us at info@maxfacs.com for more information on our services.			
Planning Service Total			

To ensure optimal quality of treatment planning services, MAXFACS reserves the right to custom process any image at the expense of the requesting dentist. MAXFACS will inform/advise the requesting dentist of any required additional services prior to engagement of services.

Payment Information

Amount Authorized: ______________________________

Credit Card: ❑ MasterCard ❑ Visa Expiration: __ __ / __ __ (Month / Year)

Name on Card: ______________________________

Credit Card #: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

CVV2: __ __ __ (3 digit security code)

Authorization:

Name (Print): ______________________________

Signature: ______________________ Date: ______________________

Disclaimer: By signing above, Surgeon understands and agrees that he must use his own independent professional judgment based on factors and information other than the ordered services when treating the patient and that neither the professional consultants who completed the ordered services ("Consultant"), nor MAXFACS Imaging Technology Corporation makes any warranty regarding the services. Surgeon bears the risk of liability arising out of his use of or reliance on the ordered services and will indemnify and hold harmless the Consultant and MAXFACS Imaging Technology Corporation from and against any and all liabilities, costs, damages, expenses and attorney fees attributable to any and all acts or omissions of Surgeon.

Treatment Planning & Consultation Questionnaire

The purpose of our Treatment Planning Service is to analyze your patient's CT scan data and the doctor's treatment plan to create a treatment plan utilizing SimPlant software. A surgical/prosthetic blueprint of the patient's treatment will be created.

Date: ______________________________

Patient Name: ______________________________

Surgery Date: ______________________________ Best Time for Web-Meeting: ______________________________

Implant Surgeon: ______________________________ E-mail: ______________________________

Office Phone: ______________________________ Cell Phone: ______________________________

Restorative Doctor: ______________________________ Office Phone: ______________________________

Treatment Planning Software: SimPlant ❑ OneShot ❑ Planner ❑ Pro ❑ Master

Arch to Receive Treatment: ❑ Maxilla ❑ Mandible ❑ Both

RESTORATIVE TREATMENT PLAN:

SCREW RETAINED / DESIRED STYLE OF RESTORATIONS:

❑ One Piece UCLA ❑ Separate Abutment from Crown

Angled abutments acceptable? ❑ Yes ❑ No

CEMENTABLE / DESIRED STYLE OF ABUTMENTS:

Angled abutments acceptable? ❑ Yes ❑ No

PROSTHETIC CONSIDERATIONS:

Units to be Splinted ❑ Yes ❑ No If yes, list splinted segments:

____

Individual Restorations? ❑ Yes ❑ No If yes, list units:

____

Additional Comments: ______________________________

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SURGICAL TREATMENT PLAN:

SURGICAL CONSIDERATIONS:

Tooth or teeth position to be restored: ______________________________

Number of implants to be placed: ______________________________

Brand of implant to be placed (Company, Platform, Shape): ______________________________

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Minimum dimension on implants that can be placed: ______________________________

Desired spacing of implants: ______________________________

Planned surgical procedures that will alter the treatment plan (e.g. Sinus Lift, Bone Graft, etc.).

Please Explain: ______________________________

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Additional Comments: ______________________________

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MAXFACS Imaging Technology Corporation · 123 Edward St., Suite 705 · Toronto, ON M5G 1E2
Phone (416) 961-MFAC · Fax (416) 962-MFAC · www.maxfacs.com