

## **CT Dental Scan Appointment Form**

Lake Forest Hospital

Diagnostic Imaging 1000 North Westmoreland Road Main Entrance Lake Forest, Illinois 60045 TEST RESULTS/QUESTIONS: 847.535.6300

SCHEDULING: 847.535.8000 office 847.535.8001 fax nm.org

Your physician has decided that a high-resolution Computed Tomography (CT) scan is needed to assist in delivering to you the best possible treatment.

Please be advised that most insurance providers do not consider this exam to be medically necessary and therefore you may be responsible for the full charge of the exam. To make an appointment, please call one of the listed imaging centers most convenient to you. On the day of your exam, the imaging center will ask for your payment up front. The charge for the exam is \$449 for each jaw. Your physician will receive the results of your CT examination in about 7 business days from the day of your examination.

Please arrive about 15 minutes early to complete our registration form. Your exam is painless and lasts approximately 30 minutes. It is very important to hold completely still when the technologist performing your exam instructs you that pictures are ready to be taken. If your physician has given you a special appliance to wear during the exam, please make sure that you bring it with you and inform the technologist before the exam begins.

		□ MAXILLA (UPPER ARCH) \$449 Due at time of service	
		☐ MANDIBLE (LOWER ARCH) \$449 Due at time of service	
Call results to:		STENT REQUIRED	
		STENT NOT REQUIRED	
Fax results to:		$\Box$ ONE SHOT (\$169 PER ARCH) Due at time of service	
PATIENT INFORMATION	1		
		RESULTS TO PHYSICIAN:	
		□ Report	
Last Name	First Name	□ Disk	
		Paper Print	
Date of Birth			
		Copy of report to:	
Home Phone Number	Work/Cell Phone Number		
PHYSICIAN INFORMATIO	ON		
Referring Practitioner Last Name	First Name		
		Notes:	
NPI #	Practitioner's Fax Number		
Practitioner's Signature	Date		
SIGNS AND SYMPTOMS/	DIAGNOSIS/ICD CODE(S)		
When ordering multiple tests on the	he same order form, please indicate a sign, symptom,	Registration may request a copy of your ID/insurance card for	
diagnosis or ICD Code(s) for each test/treatment. Do not include a "rule-out" diagnosis.		identification only. You and your insurance company will not be billed.	
		Present this form to Registration on your appointment date.	
		Registrar:	
		Plancode: P95	
		Patient Complaint: V76.12 Mail to Address: Rilling Manager, Northwestern Medicine	
		Mail to Address: Billing Manager, Northwestern Medicine Lake Forest Hospital	
		660 North Westmoreland Road	
		Lake Forest, IL 60045	

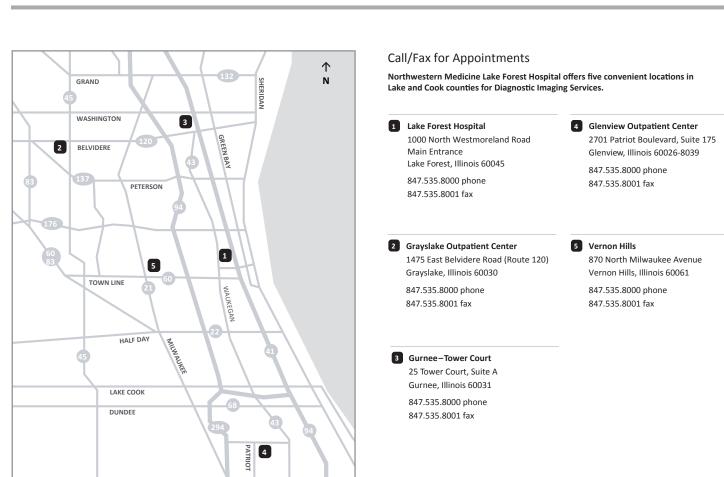


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main telephone	847.234.5600	website	nm.org
patient scheduling	847.535.8000	physician referral	847.535.6171