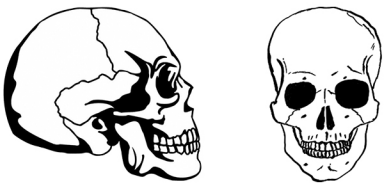
Cephalometric Tracing Request

Orthodent®



Name: _____

Address: _____

City: _____ Prov.: _____

Tel: (_____) _____

Return Date (allow min. 7 days)**:** _____

Patient Name: _____

Patient's Date of Birth: _____

X-ray Date: _____

Please check one of the following:

☐ Caucasian ☐ Black

☐ Latino ☐ Oriental

Sex:

☐ Male

☐ Female

Items enclosed for analysis:

☐ Ceph ☐ Pan

☐ Models

Model analysis?

☐ Yes ☐ No

Type of Analysis? _____

Special Instructions: _____

_____

_____

Signature: _____