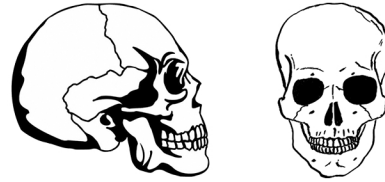


Cephalometric Tracing Request

LOCKSTAR
Dental Laboratories



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: _____