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: _____

Email: info@lockdental.com
lockdental.com • lockstardental.com