

# Ortho-Dent Ceph Tracing Request

311 Viola St.  
Oshawa, ON L1H 3A7  
Tor: (905) 427-2872  
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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:**

- |                                    |                                   |
|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> Black    |
| <input type="checkbox"/> Latino    | <input type="checkbox"/> Oriental |

**Sex:**

- Male  
 Female

**Items enclosed for analysis:**

- |                                 |                              |
|---------------------------------|------------------------------|
| <input type="checkbox"/> Ceph   | <input type="checkbox"/> Pan |
| <input type="checkbox"/> Models |                              |

**Model analysis?**

- Yes  No

**Type of Analysis?** \_\_\_\_\_

**Special Instructions:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature:** \_\_\_\_\_