CEPHALOMETRIC TRACING
ORDER FORM

Dr. ______________________ Acct. No. ______________ Date: ______________

Address ______________________ Date Needed: ______________

____

Phone # ______________________

Patient: ______________________ (Please Print) **M/F** **Date of Birth** ______________

Date of X-Ray ______________________ Dr.'s Case No. ______________

If X-Ray quality is poor, please note any special instructions for tracing: ______________________

____

Tracing Analysis Preferred (pick one)

______	Steiner	______	Broadbent	______	Brehm	______	Other
______	Ricketts	______	Mod. Steiner	______	Customized		
______	McNamara	______	Sassouni Plus		(*Name*) ______________		
					One time setup charge $40.00. Please call.		

CEPHALOMETRIC TRACINGS AND STUDY MODELS:

______ 1. Tracing and Analysis Measurements

______ 2. Sassouni Bottom Line

______ 3. Additional Analyses from Original Tracing -Name of Analysis ______________

______ 4. Study Models from your Impressions } I.D. Standard ______________

______ 5. Study Models from your working Models } Special ______________

______ 6. Follow-Up Tracing and Superimposition of Original Tracing. Date of Original X-Ray ______________

______ 7. Additional Serial Impositions Dates 1. ________ 2. ________ 3. ________ 4. ________

Packages

______ A. 1, 2, 3 above

______ B. "A" package plus models from your impression

______ C. "A" package plus models from your models

STUDY MODEL ID

Standard:	Back of Upper	-	Line #1	Patient Name	Date
			Line #2	Patient Age	
			Line #3	Doctor's Name	
	Back of Lower	-	Line #1	Patient Name	
Special:	Back of Upper	-	Line #1	______________	
			Line #2	______________	
			Line #3	______________	
	Back of Lower	-	Line #1	______________	
			Line #2	______________	
	Front of Lower	-		______________	
	Front of Upper	-		______________	

Price - Does not include pick up and delivery charges - See Price List
Billing and Term Options - See Price List

______________ Invoice to Doctor - Net 20

Dockstader, Inc.
FULL SERVICE DENTAL LAB

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