CEPH ANALYSIS
ORTHO PLANS

☐ CEPH TRACING REQUIREMENTS

DR. ____________________

PT. ____________________ **GENDER:** ☐ **MALE** ☐ **FEMALE**

D.O.B. ____/____/____ **ETHNICITY:** ____________

CEPH IMAGE ☐ **DATE TAKEN:** ____/____/____

☐ ORTHO PLAN REQUIREMENTS

- ☐ **CEPH TRACING COMPLETED**
- ☐ **UPPER AND LOWER MODELS**
- ☐ **PATIENT PHOTOS**
- ☐ **PANO IMAGE**
- ☐ **DATE RECORDS TAKEN:** ____/____/____

DR. x ______________________ **DATE:** ____/____/____

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