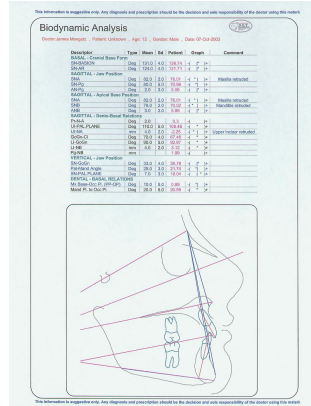




# CEPHALOMETRIC ANALYSIS REQUEST FORM



Patient Name: \_\_\_\_\_

Male Female

Patient Age: \_\_\_\_\_ Years Date records made: \_\_\_\_\_

Email your cephalometric x-ray to: [trace@cephanalysis.com](mailto:trace@cephanalysis.com)

Mail your original cephalometric x-ray to: **D.E.T. • 11424 Cherisse Dr. • Austin, TX 78739 USA**

## CEPHALOMETRIC ANALYSIS REQUESTED (Please circle analyses needed):

ABO  
Burstone  
DiPaulo  
Harvold  
McLaughlin  
Owen Block  
Rondeau  
Tweed

Bjork  
Clark  
Downs  
Kois  
McNamara  
POS  
Sassouni  
V.T.O Holdaway

Burlington  
COGS  
Eastman  
McGann  
Modified Steiner  
Ricketts  
Steiner  
Wits

\* custom analyses available

### I WOULD LIKE TO:

Email my cephalometric x-ray for analysis	\$37.00 U.S.
Mail my cephalometric x-ray for analysis	\$45.00 U.S.
Organize patient records- Photos, Models and X-rays	\$15.00 U.S.
Return my cephalometric tracing to me via email	No Charge
Return my cephalometric tracing to me via mail	No Charge

Payment to D.E.T. must be included with records and order form Total: \$ \_\_\_\_\_ U.S.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

I will pay by: Check (enclosed- mailed ceph only) MC Visa Amount Payable to D.E.T. :\$ \_\_\_\_\_

Acct. Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ 3-4 digit security code: \_\_\_\_\_

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