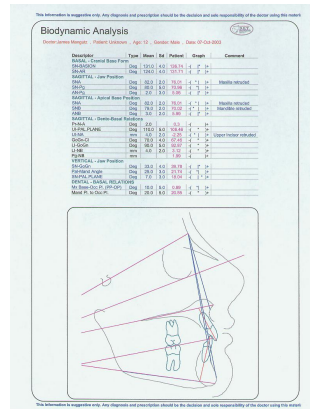




CEPHALOMETRIC ANALYSIS REQUEST FORM



Patient Name: _____

Male **Female**

Patient Age: _____ **Years** **Date records made:** _____

Email your cephalometric x-ray to: **trace@cephanalysis.com**

Mail your original cephalometric x-ray to: **D.E.T. • 330 Lochaven Road • Waterford, MI 48327 USA**

CEPHALOMETRIC ANALYSIS REQUESTED (Please circle analyses needed):

Biodynamic
Burstone
DiPaulo
Harvold
McNamara
POS
Sassounni
Tweed

Bjork
Clark
Downs
McGann
Modified Steiner
Ricketts
SLU
V.T.O Holdaway

Burlington
COGS
Eastman
McLaughlin
Owen Block
Rondeau
Steiner
Wits

*** custom analyses available**

I WOULD LIKE TO:

- | | |
|---|--------------|
| Email my cephalometric x-ray for analysis | \$35.00 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 vial email | No Charge |
| Return my cephalometric tracing to me vial 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: _____