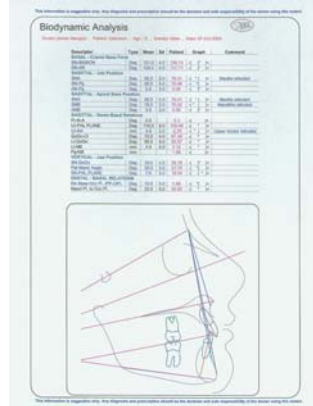




CEPHALOMETRIC ANALYSIS REQUEST FORM



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 check one):

- | | | |
|--|--|--|
| <input type="checkbox"/> Biodynamic | <input type="checkbox"/> Bjork | <input type="checkbox"/> Burlington |
| <input type="checkbox"/> Burstone | <input type="checkbox"/> Clark | <input type="checkbox"/> COGS |
| <input type="checkbox"/> McGann | <input type="checkbox"/> McLaughlin | <input type="checkbox"/> McNamara |
| <input type="checkbox"/> Owen | <input type="checkbox"/> Block | <input type="checkbox"/> Ricketts |
| <input type="checkbox"/> Sassounni | <input type="checkbox"/> Steiner | <input type="checkbox"/> Tweed |
| <input type="checkbox"/> V.T.O | <input type="checkbox"/> Holdaway | <input type="checkbox"/> Wits |
- * custom analysis available under certain conditions

I WOULD LIKE TO:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Email my cephalometric x-ray for analysis | <input type="checkbox"/> \$30.00 U.S. |
| <input type="checkbox"/> Mail my cephalometric x-ray for analysis | <input type="checkbox"/> \$40.00 U.S. |
| <input type="checkbox"/> Return my cephalometric tracing to me vial email | <input type="checkbox"/> No Charge |
| <input type="checkbox"/> Return my cephalometric tracing to me vial mail | <input type="checkbox"/> 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: _____