



CEPHALOMETRIC ANALYSIS REQUEST FORM



Value	Norm	Std Dev	Dev	Dev
6420 - Cranial Base Point	120.0	230.0	4.0	0.4
6421 - Basion (°)	120.0	230.0	4.0	0.4
6422 - Basion (°)	120.0	230.0	4.0	0.4
6423 - Basion (°)	120.0	230.0	4.0	0.4
6424 - Basion (°)	120.0	230.0	4.0	0.4
6425 - Basion (°)	120.0	230.0	4.0	0.4
6426 - Basion (°)	120.0	230.0	4.0	0.4
6427 - Basion (°)	120.0	230.0	4.0	0.4
6428 - Basion (°)	120.0	230.0	4.0	0.4
6429 - Basion (°)	120.0	230.0	4.0	0.4
6430 - Basion (°)	120.0	230.0	4.0	0.4
6431 - Basion (°)	120.0	230.0	4.0	0.4
6432 - Basion (°)	120.0	230.0	4.0	0.4
6433 - Basion (°)	120.0	230.0	4.0	0.4
6434 - Basion (°)	120.0	230.0	4.0	0.4
6435 - Basion (°)	120.0	230.0	4.0	0.4
6436 - Basion (°)	120.0	230.0	4.0	0.4
6437 - Basion (°)	120.0	230.0	4.0	0.4
6438 - Basion (°)	120.0	230.0	4.0	0.4
6439 - Basion (°)	120.0	230.0	4.0	0.4
6440 - Basion (°)	120.0	230.0	4.0	0.4
6441 - Basion (°)	120.0	230.0	4.0	0.4
6442 - Basion (°)	120.0	230.0	4.0	0.4
6443 - Basion (°)	120.0	230.0	4.0	0.4
6444 - Basion (°)	120.0	230.0	4.0	0.4
6445 - Basion (°)	120.0	230.0	4.0	0.4
6446 - Basion (°)	120.0	230.0	4.0	0.4
6447 - Basion (°)	120.0	230.0	4.0	0.4
6448 - Basion (°)	120.0	230.0	4.0	0.4
6449 - Basion (°)	120.0	230.0	4.0	0.4
6450 - Basion (°)	120.0	230.0	4.0	0.4

Patient Name: _____
 Male Female
 Patient DOB: _____

Date records made: _____

Email your cephalometric x-ray to: **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 all analyses needed):

- | | | |
|------------|------------|------------------|
| ABO | Biodynamic | Bjork |
| Burstone | Clark | COGS |
| DiPaulo | Downs | Eastman |
| Harvold | Kois | McGann |
| McLaughlin | McNamara | Modified Steiner |
| Owen Block | POS | Ricketts |
| Rondeau | Sassouni | Steiner |
| Tweed | Wits | |

**custom analyses available free of charge*

I WOULD LIKE TO:

- | | |
|---|--------------|
| Email my cephalometric x-ray for analysis | \$39.00 U.S. |
| Mail my cephalometric x-ray for analysis | \$45.00 U.S. |
| Superimposition* plus the cost of pre and post tracings | \$25.00 U.S. |
| Organize patient records- Photos, Models and X-rays | \$26.00 U.S. |

*Request for 24hr service-additional fee \$5.00 U.S.

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 Amex Amount Payable to D.E.T.: \$ _____
 Acct. Number: _____ Exp. Date: _____ 3-4 digit security code: _____
 Signature: _____