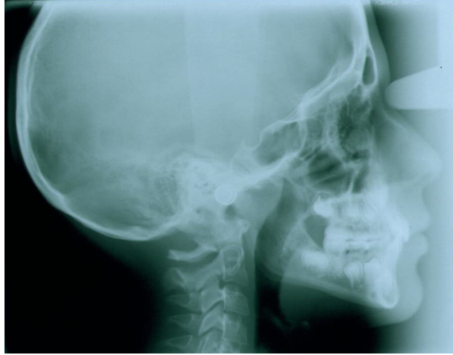
CEPHALOMETRIC ANALYSIS REQUEST FORM



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	**Sassounni**	**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: ____