



# CEPHALOMETRIC ANALYSIS REQUEST FORM



	Value	Norm	Std Dev	Dev Norm
<b>MEAS - Cranial Base Plane</b>				
S1 - S2 (°)	128.0	128.0	4.0	-0.4
S1 - S3 (°)	125.0	124.0	3.0	-0.3
<b>MEAS - Jaw Position</b>				
SNB (°)	84.0	80.0	3.0	-0.8
SNL (°)	76.0	80.0	3.0	-1.3
SNP (°)	70.0	72.0	2.0	-1.0
<b>MEAS - Arc of Max Rotation</b>				
SNB (°)	84.0	80.0	3.0	-0.8
SNL (°)	76.0	80.0	3.0	-1.3
SNP (°)	70.0	72.0	2.0	-1.0
<b>MEAS - Angle Head Rotation</b>				
SN (°)	5.1	2.0	1.0	0.9
SNL (°)	14.0	10.0	2.0	1.0
SNP (°)	4.0	4.0	2.0	0.0
SNM (°)	10.0	10.0	2.0	0.0
SNR (°)	7.0	8.0	1.8	-1.1
SNL (°)	14.0	10.0	1.8	1.4
<b>MEAS - Jaw Position</b>				
S1 - S2 (°)	128.0	128.0	4.0	-0.4
S1 - S3 (°)	125.0	124.0	3.0	-0.3
<b>MEAS - Mandible Rotation</b>				
SNB (°)	84.0	80.0	3.0	-0.8
SNL (°)	76.0	80.0	3.0	-1.3
SNP (°)	70.0	72.0	2.0	-1.0
<b>MEAS - Angle Head Rotation</b>				
SN (°)	5.1	2.0	1.0	0.9
SNL (°)	14.0	10.0	2.0	1.0
SNP (°)	4.0	4.0	2.0	0.0
SNM (°)	10.0	10.0	2.0	0.0
SNR (°)	7.0	8.0	1.8	-1.1
SNL (°)	14.0	10.0	1.8	1.4

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

Male    Female

Patient DOB: \_\_\_\_\_

Date records made: \_\_\_\_\_

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

## F.O.R.C.E./Litt Biodynamic Cephalometric Analysis

### I WOULD LIKE TO:

Email my cephalometric x-ray for analysis

\$39.00 U.S.

Organize patient records — Photos, Models, X-rays-HIPPA/PHIPPA protection

\$26.00 U.S.

\*Request for 24hr service-additional fee \$10.00 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: MC    Visa    Amex    Amount Payable to D.E.T.: \$ \_\_\_\_\_

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

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