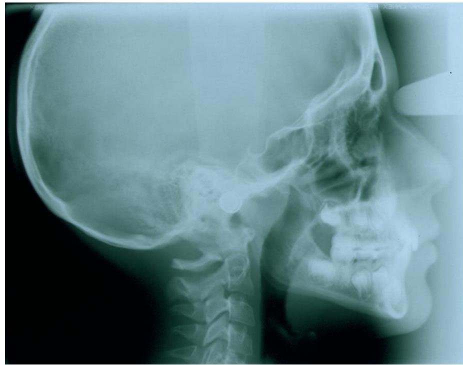
CEPHALOMETRIC ANALYSIS REQUEST FORM



Patient Name: ______________________________ **Male** **Female**

Patient DOB: _______________ **Date records made:** ____________

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

<u>F.O.R.C.E./Litt Biodynamic Cephalometric Analysis</u>

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: ____