



## CEPHALOMETRIC ANALYSIS REQUEST FORM



Variable	Value	Norm	Std Dev	Dev Std
<b>SKULL - Cranial Base Plane</b>				
S1 - S2 (°)	128.0	128.0	4.0	-0.4
S1 - S3 (°)	125.0	124.0	3.0	-0.2
<b>SKULL - Jaw Position</b>				
SNB (°)	84.0	80.0	3.0	0.0
SNL (°)	76.0	80.0	3.0	-1.0 *
SNM (°)	76.0	75.0	2.0	-0.1 *
<b>MANDIBLE - Arc of Curve Rotation</b>				
MP (°)	84.0	80.0	3.0	0.0
MP (°)	76.0	75.0	2.0	-0.1 *
MP (°)	76.0	75.0	2.0	-0.1 *
<b>SKULL - Orbit-Base Relations</b>				
Orbit (°)	5.1	2.0	1.0	-0.0
S1 - Orbit (°)	124.0	120.0	4.0	-0.0
S1 - Orbit (°)	4.0	4.0	2.0	1.0
Orbit - Orbit (°)	120.0	120.0	2.0	-0.0
S1 - Orbit (°)	7.0	8.0	1.0	-1.0 **
Orbit - Orbit (°)	5.0	5.0	1.0	0.0
<b>MANDIBLE - Jaw Position</b>				
S1 - Mand (°)	30.0	30.0	0.0	0.0
S1 - Mand (°)	30.0	30.0	0.0	0.0
Mand - Mand (°)	30.0	30.0	0.0	0.0
<b>MANDIBLE - Mandible-Base Relations</b>				
Mand - Orbit (°)	3.0	3.0	0.0	0.0
Mand - Orbit (°)	3.0	3.0	0.0	0.0
<b>MANDIBLE - Mandible-Base Relations</b>				
Mand - Orbit (°)	3.0	3.0	0.0	0.0
Mand - Orbit (°)	3.0	3.0	0.0	0.0
<b>MANDIBLE - Mandible-Base Relations</b>				
Mand - Orbit (°)	3.0	3.0	0.0	0.0
Mand - Orbit (°)	3.0	3.0	0.0	0.0

**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**

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

#### 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                                      | \$20.00 U.S. |
| Organize patient records – Photos, Models and X-rays | \$22.00 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: \_\_\_\_\_