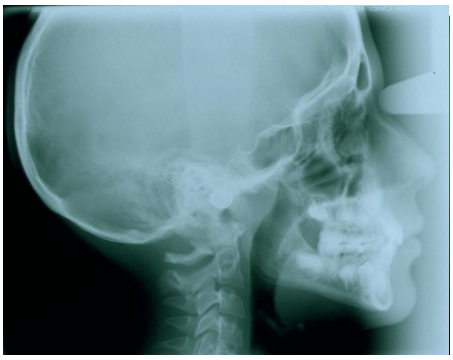
Jason G. McClellan, President
D.E.T.
Digitize and Electronic Transfer
11424 Cherisse Dr.
Austin, TX 78739 USA
trace@cephanalysis.com
(248) 830-0209

CEPHALOMETRIC ANALYSIS REQUEST FORM



Patient Name: _____ **Male ☐ Female ☐**

Patient Age: _____ **Years** **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	$38.00 U.S.
Mail my cephalometric x-ray for analysis	$45.00 U.S.
Organize patient records – Photos, Models and X-rays	$20.00 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: _____