Shaw Group
of DENTAL LABORATORIES

Orthodontic Department

Cephalometric and Study Model Analysis Request Form

Practice Name: _____ Patient's Name: _____

Doctor's Name: _____ Date of Birth: _____

Address: _____ Records Created: _____

City, Postal Code: _____ Return Date: _____

Telephone: _____ Male ☐ Female ☐

Email: _____

Email your Digital X-ray, photos and/or scans to: **digital@shawlabgroup.com**

Please check required analysis:

Lateral		Frontal	
Ricketts	☐	Ricketts	☐
McNamara	☐	Van Arsdale	☐
Steiner + Witts	☐	Grummons	☐
Jarabak	☐		
Bjork	☐		
Downs	☐		

Other (please specify):_____

Only edit and organize photos ☐

Organize photos, models & x-rays ☐

Orthodontic Study Models:

Items enclosed for model analysis:		Please check required analysis:	
Impressions	☐	Bolton	☐
Models	☐	Schwartz	☐
Bite Registration	☐		
Scans	☐		

Comments: _____ **Signature**_____

_____

_____

_____

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