

MODERN  
ORTHODONTICS



The word "MODERN" is positioned above the central graphic, and the word "ORTHODONTICS" is positioned below it, both written in a blue, sans-serif font. The letters are slightly slanted and arranged in a circular arc around the central tooth illustration. Two small yellow five-pointed stars are placed on either side of the central graphic, one to the left and one to the right.

STYLE GUIDE

## COLOR GUIDE



HEX #0F486B | 8483 C



HEX #EC8C27 | P 20-8 C



HEX #4D9CBA | 7703 U



HEX #F4BA32 | 7406 U



HEX #9BC8E4 | 283 UP

## LOGO VARIATIONS

*Primary (Circular)*



MODERN  
ORTHODONTICS

*Alternate (Stacked)*



*Secondary (Horizontal)*



*Submark (Icon)*





★ MODERN ★  
ORTHODONTICS

## TYPOGRAPHY

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The Headline

Aa

Dosis Medium

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The Subheadline

Aa

Dosis Regular

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Body copy

Aa

Barlow Light





## LOGO LAYOUTS



Never change the color of the logo.



Never change, stretch, or distort the form of the logo.



Never place the logo on a busy or distracting background.





# BUSINESS CARD



# LETTER HEAD

Call (562) 472-0447

Email modernorthodonticslongbeach.com

Email smile@modernortholb.com

Address 6543 E Spring St, Unit A6  
Long Beach, CA 90808



MM/DD/YY

## Dear Patient

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DR. HELIA JAFARI  
Board Certified Orthodontist

# REFERRAL PAD



(562) 472-0447

[modernorthodonticslongbeach.com](http://modernorthodonticslongbeach.com)

[smile@modernorthob.com](mailto:smile@modernorthob.com)

6543 E Spring St, Unit A6  
Long Beach, CA 90808

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

Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Phone Number: \_\_\_\_\_ Referred by: \_\_\_\_\_

**Areas of Concern:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Crowding                        | <input type="checkbox"/> Spacing         | <input type="checkbox"/> Overjet              |
| <input type="checkbox"/> Openbite                        | <input type="checkbox"/> Crossbite       | <input type="checkbox"/> Missing Teeth        |
| <input type="checkbox"/> Impacted Teeth                  | <input type="checkbox"/> Pre-prosthetics | <input type="checkbox"/> Orthognathic Surgery |
| <input type="checkbox"/> Overbite                        |  | <input type="checkbox"/> Space Maintenance    |
| <input type="checkbox"/> Early or Interceptive Treatment |  | <input type="checkbox"/> Other _____          |

**Dental History:**

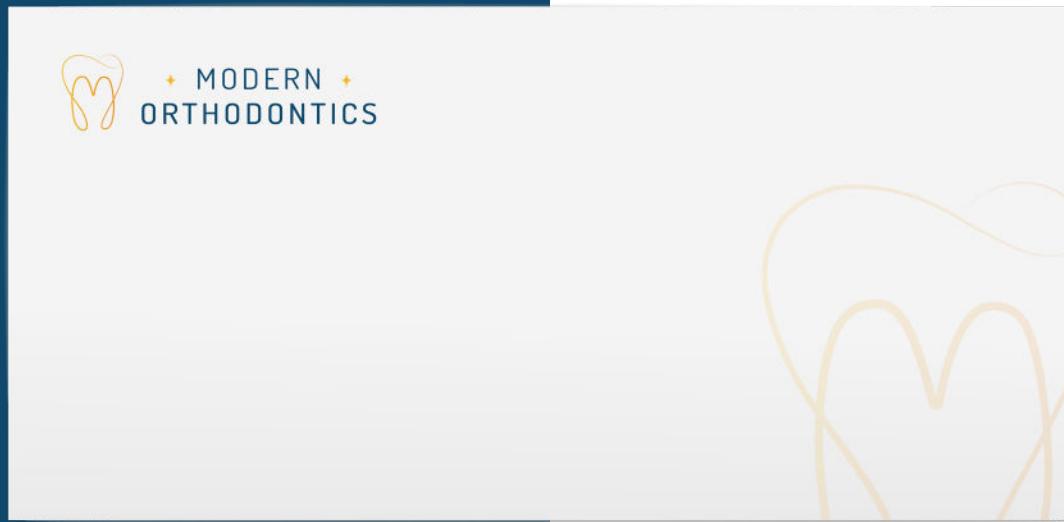
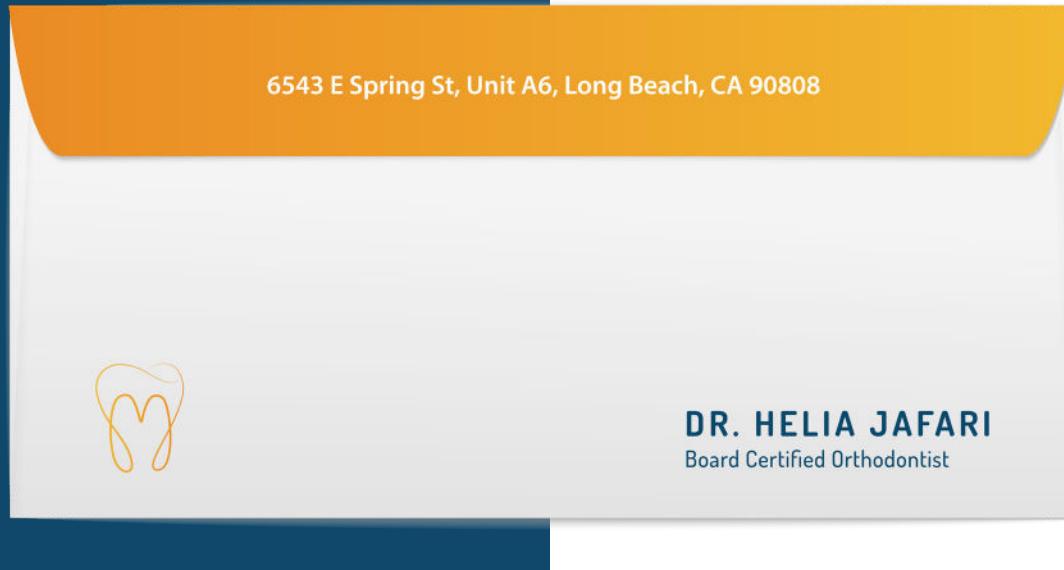
- Date of last cleaning and checkup \_\_\_\_\_
- Panoramic radiograph is available \_\_\_\_\_
- Restorative work needed \_\_\_\_\_

**Comments or Special Instructions:**

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# ENVELOPE



# FOLDER

