

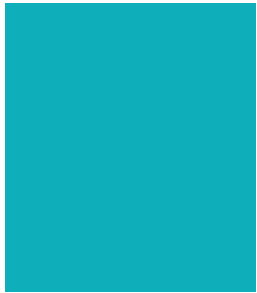


**ORTHODONTICS
OF WEST NYACK**

— DR. CAMPBELL & DR. KAPLAN —

STYLE GUIDE

COLOR GUIDE



HEX #0FAEBB | 7466 C



HEX #98b84b



HEX #808d50



HEX #221f1f

LOGO VARIATIONS

Primary



Secondary



Alternate



Submark





**ORTHODONTICS
OF WEST NYACK**
DR. CAMPBELL & DR. KAPLAN

TYPOGRAPHY

The Headline

Aa

Readex Pro Bold

The Subheadline

Aa

Readex Pro Medium

Body copy

Aa

Readex Pro 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




**ORTHODONTICS
OF WEST NYACK**
DR. CAMPBELL & DR. KAPLAN




Sarah E. F. Kaplan, D.D.S, M.S.
Diplomate, American Board of Orthodontics
Matthew S. Campbell, D.M.D., M.S.
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 (845) 535-9548

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 2 Sickletown Road, West Nyack, NY 10994



LETTER HEAD




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REFERRAL PAD



**ORTHODONTICS
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2 Sickletown Road, West Nyack, NY 10994

Patient Name: _____

Date of Birth: _____ Patient Phone No.: _____

Referred by: _____ Date: _____

Areas Of Concern:

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

Dental History:


Date of last cleaning and checkup _____

Panoramic radiograph is available

Restorative work needed (Please detail below)

Comments or Special Instructions:





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Date: _____

Dear Dr. _____

We have asked _____ (DOB: _____)
to make an appointment to see you in your office.

Please Evaluate For (See Below):

| | |
|--|--|
| <input type="checkbox"/> New Patient Examination | <input type="checkbox"/> Exposure and Bonding as indicated |
| <input type="checkbox"/> Oral Prophylaxis | <input type="checkbox"/> Frenectomy |
| <input type="checkbox"/> Extractions as Indicated | <input type="checkbox"/> Perio Evaluation of: _____ |
| <input type="checkbox"/> Restorations as Indicated | <input type="checkbox"/> Trauma Evaluation of: _____ |
| <input type="checkbox"/> TMJ Evaluation | <input type="checkbox"/> Orthognathic Surgery Evaluation |

PERMANENT

| | | | | | | | | | | | | | | | | | |
|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|---|
| R | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | L |
| | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | |

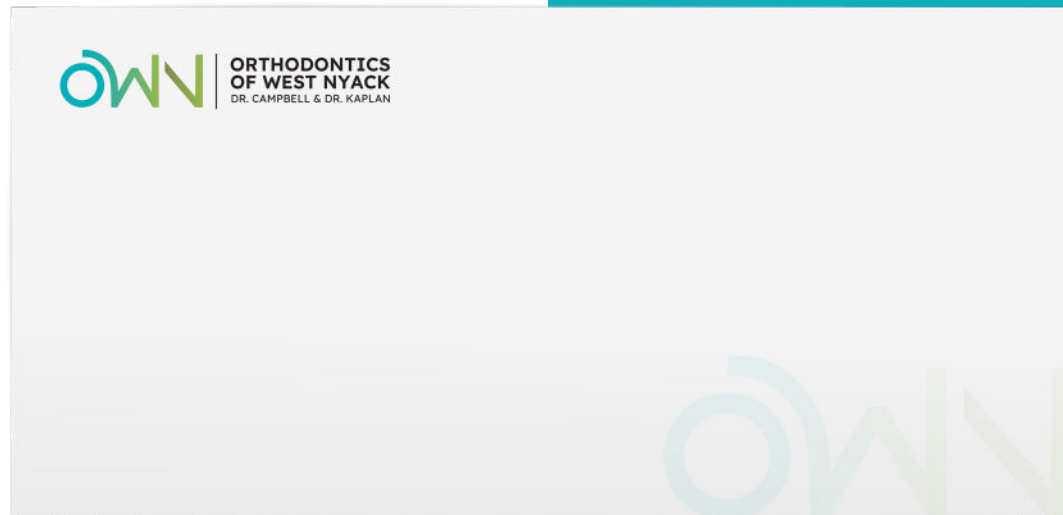
DECIDUOUS

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| R | A | B | C | D | E | F | G | H | I | J | L |
| | T | S | R | Q | P | O | N | M | L | K | |

Additional Comments:

If there are any questions regarding the above, please do not hesitate to call our office. **THANK YOU!**

ENVELOPE



FOLDER

