

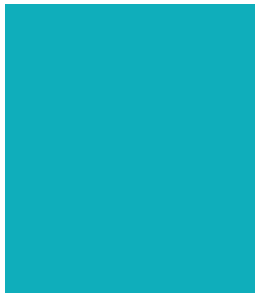


**ORTHODONTICS  
OF WEST NYACK**

— 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

The Subheadline

Body copy

**Aa**

**Readex Pro Bold**

Aa

Readex Pro Medium

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



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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:**

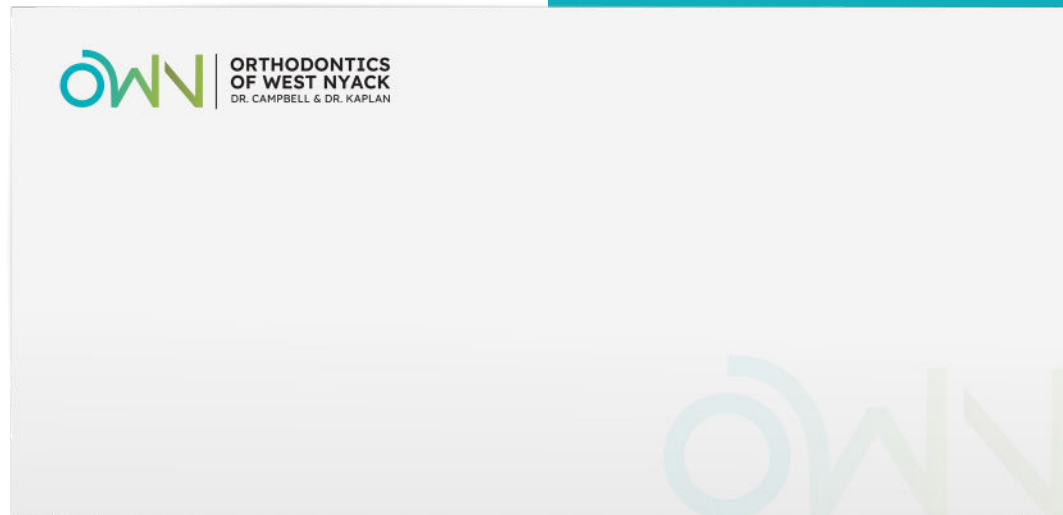
If there are any questions regarding the above, please do not hesitate to call our office. **THANK YOU!**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# ENVELOPE



# FOLDER

