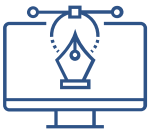
MEDICAL DENTAL
STATIONERS LTD.

PRODUCT CATALOGUE 2018

TABLE OF **CONTENTS**



CUSTOMIZED CREATIONS

Can't find what you're looking for? Our graphic design team and professional sales associates will work with you to create a unique design concept that is right for you.

GOING GREEN

We are committed to working with our team and partners to incorporate environmentally friendly business practices into our daily operations. We will continue to identify and act on opportunities to minimize our impact on the environment.

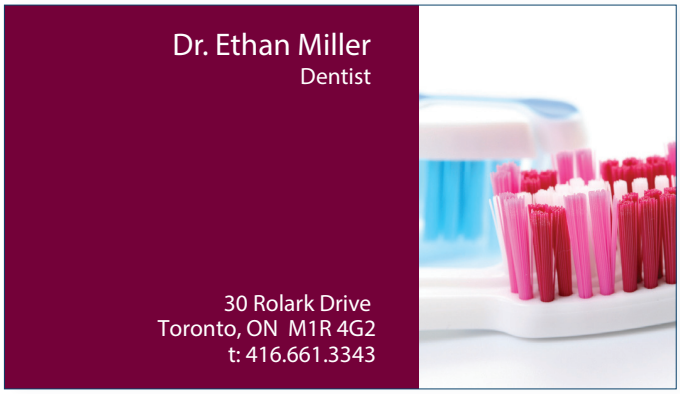
A POSITIVE EXPERIENCE

We are committed to offering you products and services that promote and grow your practice. Our friendly and knowledgeable customer service representatives are here to support you and answer any questions you may have.

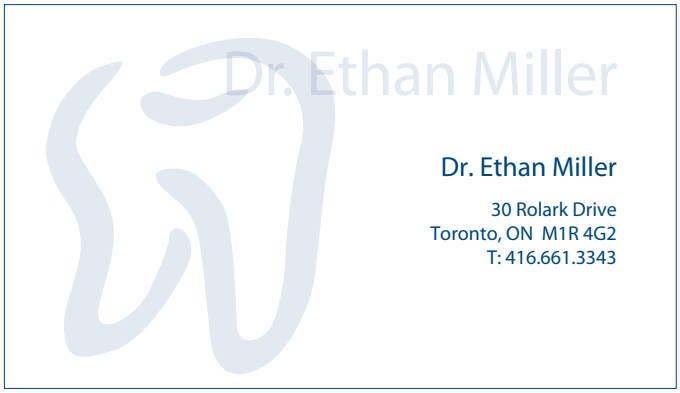
COMPETITIVE SOLUTIONS

Building a successful practice requires making the right connections along the way. When you partner with Medical-Dental Stationers Ltd., you gain access to the power of a large North American organization with the responsive service of a local professional. For more than five decades, we've provided our clients with a resource for all their print and promotional product needs.

BUSINESS CARDS



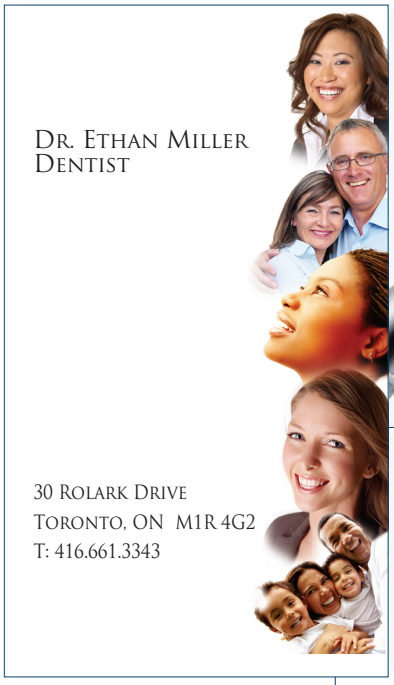
no. ST118



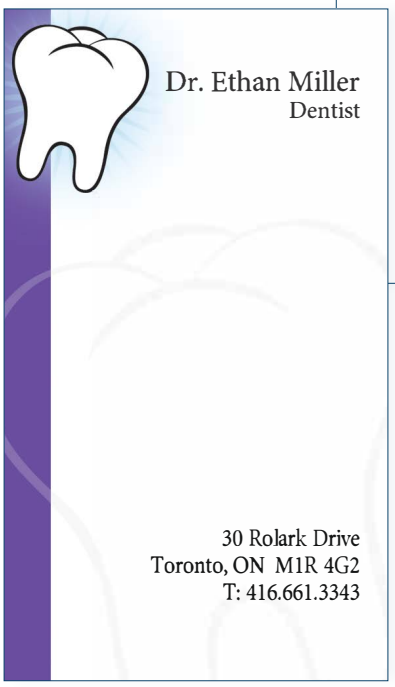
no. ST135

no. ST106

no. ST140



no. ST102



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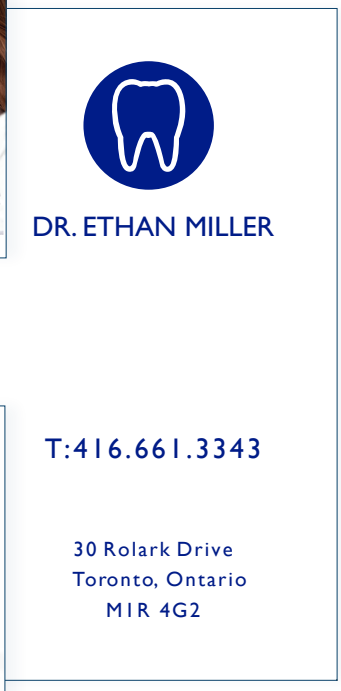


no. ST141

BUSINESS CARDS

Size 3.5" x 2" - Printed on 10pt. white premium stock, one side

Quantity	250	500	1,000	2000	5000
Full Colour	73.00	79.00	94.00	140.00	290.00

Prices are subject to change

DATE DOTS

APPOINTMENT CARDS

Date Dots are customizable with your name and address as well as your cancellation policy. Patients can peel and stick Date Dots to their calendars on the day of their appointment to keep the reminder fresh.

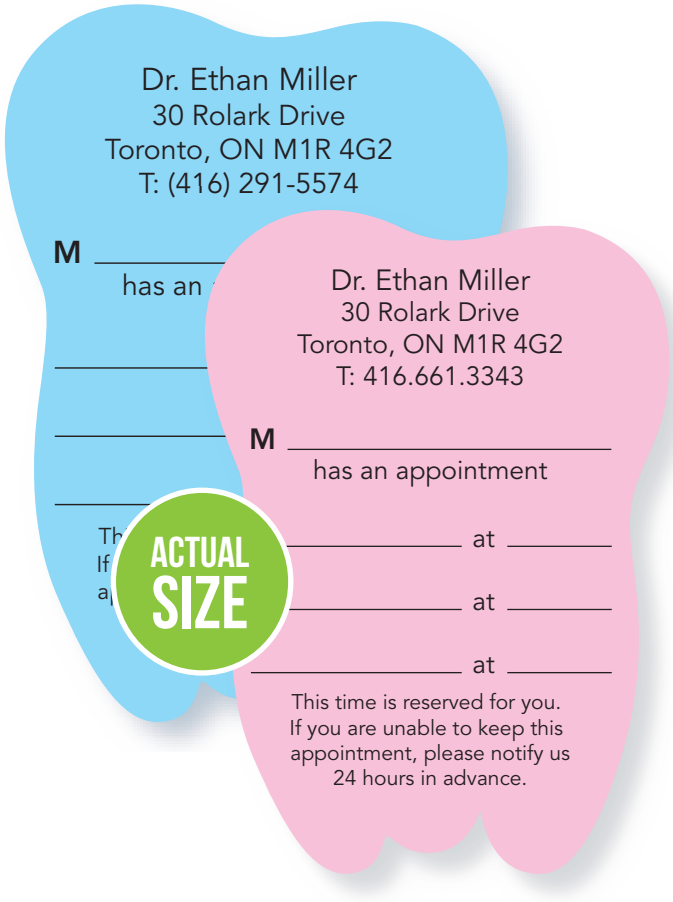
Printed on 8pt. neon green paper with three or four peel-off stickers on one side and a business card printed on the second side. Date Dots cards are available in quantities of 250, 500, 1000, 2000 or 5000.

DATE DOTS APPOINTMENT CARDS

2" x 3.5" - Printed double-sided on 8pt. flourescent green neon paper with 3 or 4 peel-off stickers.

Quantity	250	500	1,000	2000	5000
Printed Two Sides	95.00	125.00	160.00	265.00	530.00

Prices are subject to change



Die Cut Tooth Shaped Appointment Cards

Give your practice the attention it deserves with these distinctive appointment cards. Clients will not only remember their appointment, but will enjoy the unique presentation. Printed on premium quality, pastel card stock. Available in six pastel colours: blue, green, yellow, ivory, salmon, cherry.

yellow	ivory	salmon
green	blue	cherry

MAKE YOUR CARDS STAND OUT BY PRINTING THEM ON COLOUR CARDSTOCK

SMALL DIE CUT TOOTH SHAPED APPOINTMENT CARDS - SMALL

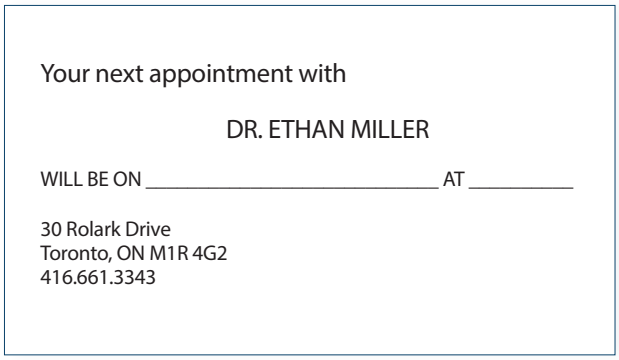
Quantity	250	500	1,000	2000	5000
Full Colour / White Stock	102.00	135.00	195.00	290.00	475.00
Black ink / White Stock	90.00	125.00	160.00	275.00	344.00

Colour stock available at extra charge. Prices are subject to change.

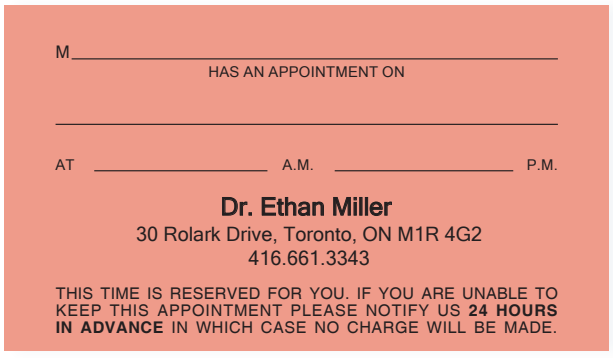
LARGE DIE CUT TOOTH SHAPED APPOINTMENT CARDS - LARGE

Quantity	250	500	1,000	2000	5000
Full Colour / White Stock	102.00	135.00	195.00	290.00	475.00
Black ink / White Stock	90.00	125.00	160.00	275.00	344.00

Colour stock available at extra charge. Prices are subject to change.



no. 9K - Appointment Card - 3.5" x 2"



no. 9B - Appointment Card - 3.5" x 2"

no. 9A - Appointment Card - 2" x 3.5"

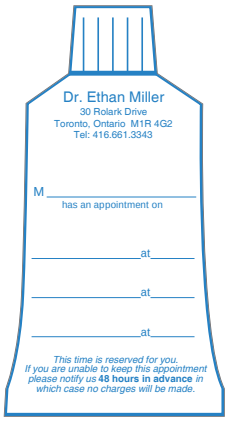
APPOINTMENT CARDS

Size 3.5" x 2" - Printed on 110lb white chart stock with black ink

Quantity	250	500	1,000	2000	5000
Black ink	60.00	65.00	70.00	92.00	195.00

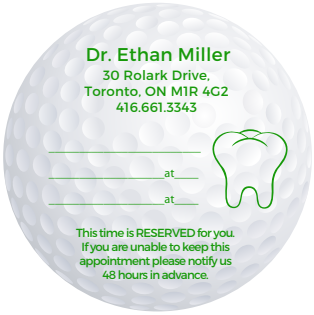
Colour stock available at extra charge. Prices are subject to change.

no. FS018 - Smiley Face

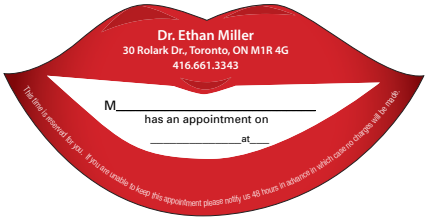


no. FS005 - Tooth Paste

no. FS003 - Apple



no. FS054 - Golf ball



no. FS017 - Smile

no. FS052 - Running Shoe

no. FS007 - Dental Floss

no. FS055 - Chatter Teeth

no. FS008- Tooth Brush

no. FS050- Appointment Card

ACTUAL SIZE NOT SHOWN

DIE CUT APPOINTMENT CARDS - 3" X 4" - 110LB WHITE STOCK					
Quantity	250	500	1,000	2000	5000
Full Colour	102.00	135.00	195.00	290.00	475.00
Black ink	90.00	125.00	160.00	275.00	344.00

Prices are subject to change.

NAME BADGES

NAME BADGES

Engraved name badges with safety-lock pins, or magnetic attachment.
Choose from a variety of brilliant colours, each with a satin smooth finish.
Minimum 2 badge order.

DR. ETHAN MILLER
#200 White with Black Lettering

DR. ETHAN MILLER
#217 Black with Yellow Lettering

DR. ETHAN MILLER
#201 White with Green Lettering

DR. ETHAN MILLER
#226 Blue with White Lettering

DR. ETHAN MILLER
#202 White with Red Lettering

DR. ETHAN MILLER
#240 Brown with White Lettering

DR. ETHAN MILLER
#203 White with Blue Lettering

DR. ETHAN MILLER
#251 Burgundy with White Lettering

DR. ETHAN MILLER
#205 Ivory with Brown Lettering

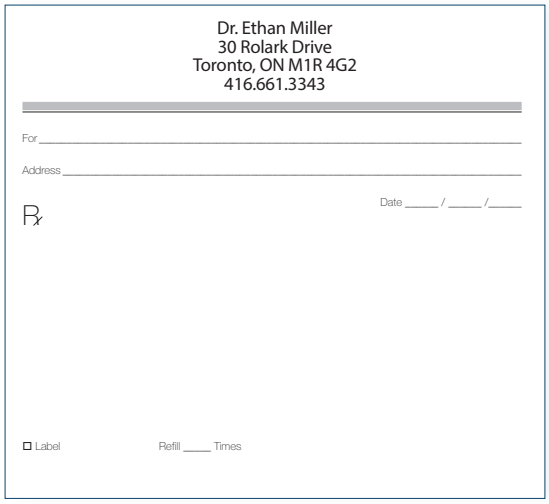
DR. ETHAN MILLER
#257 Green with White Lettering

DR. ETHAN MILLER
#210 Black with White Lettering

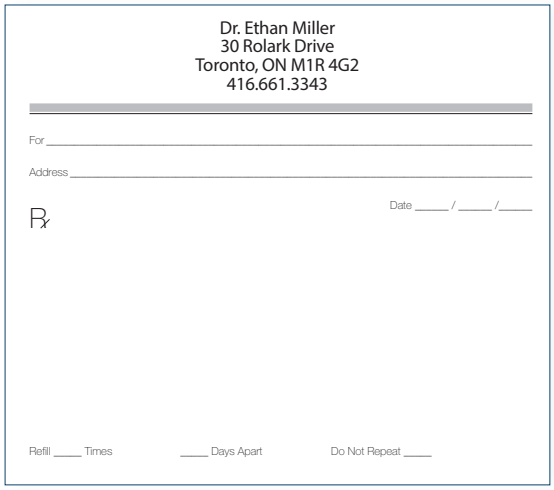
DR. ETHAN MILLER
#269 Silver Grey with Black Lettering

NAME BADGES	
2.5" x 7/8"	**Each**
Safety Pin Backing	$25.00
Magnetic Backing	$30.00

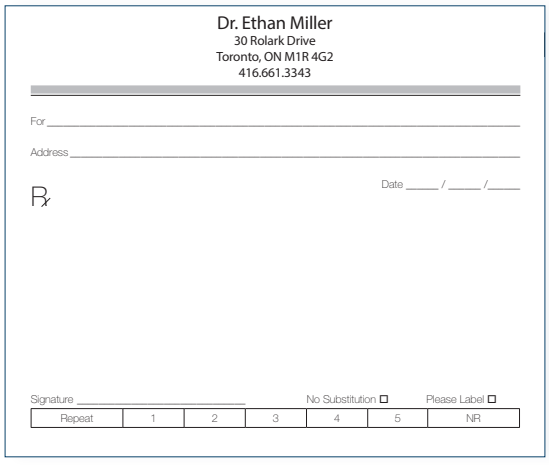
Prices are subject to change.



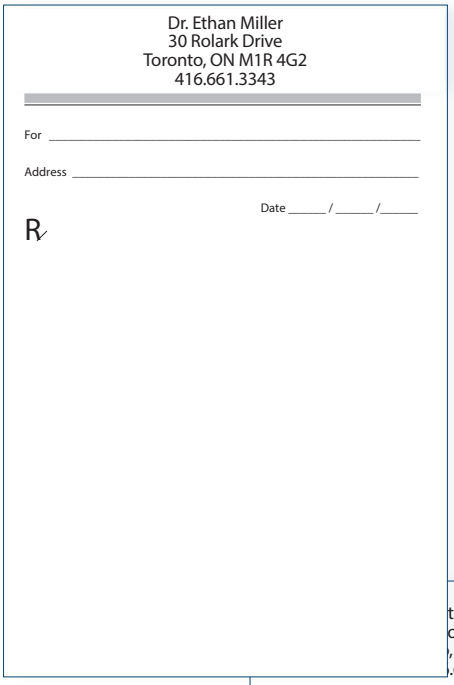
no. R01



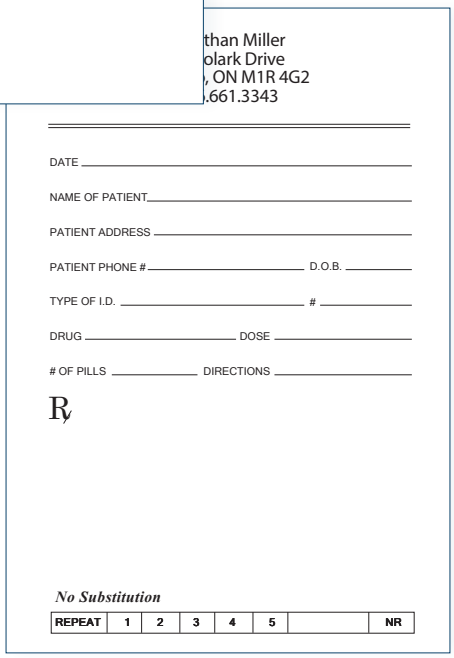
no. R02



no. R03



no. RX55



no. RX56

PADS ARE AVAILABLE AS SINGLE SHEETS OR 2 PART NCR

PRESCRIPTION PADS

RX55 - 4" x 6" - 125 Sheets per pad

Quantity	3 Pads	4 Pads	5 Pads	8 Pads	16 Pads	40 Pads
Single 125 Shts/Pad	80.00	81.00	82.00	90.00	110.00	165.00

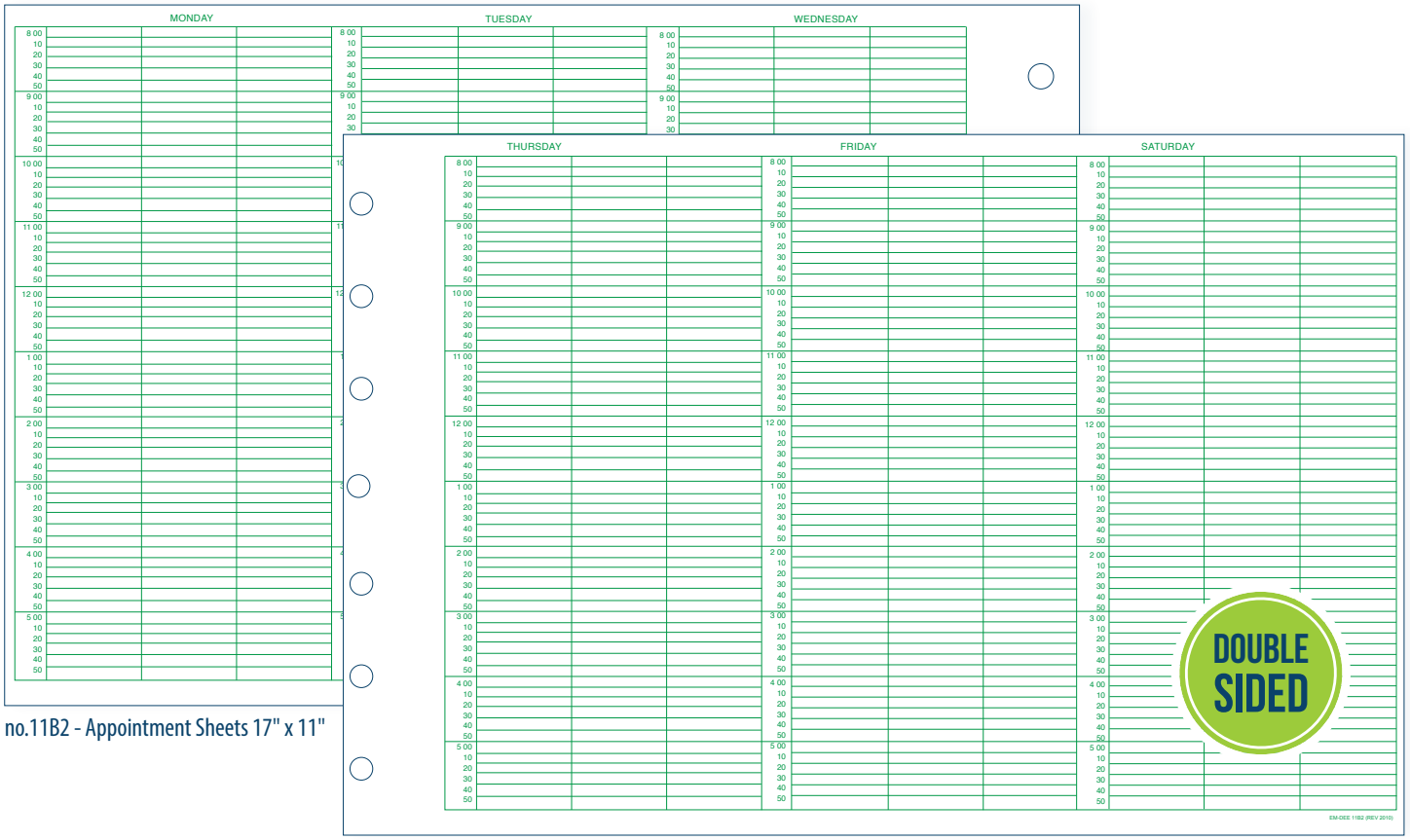
PRESCRIPTION SETS

RX56 - 4" x 6" - 2 Part NCR

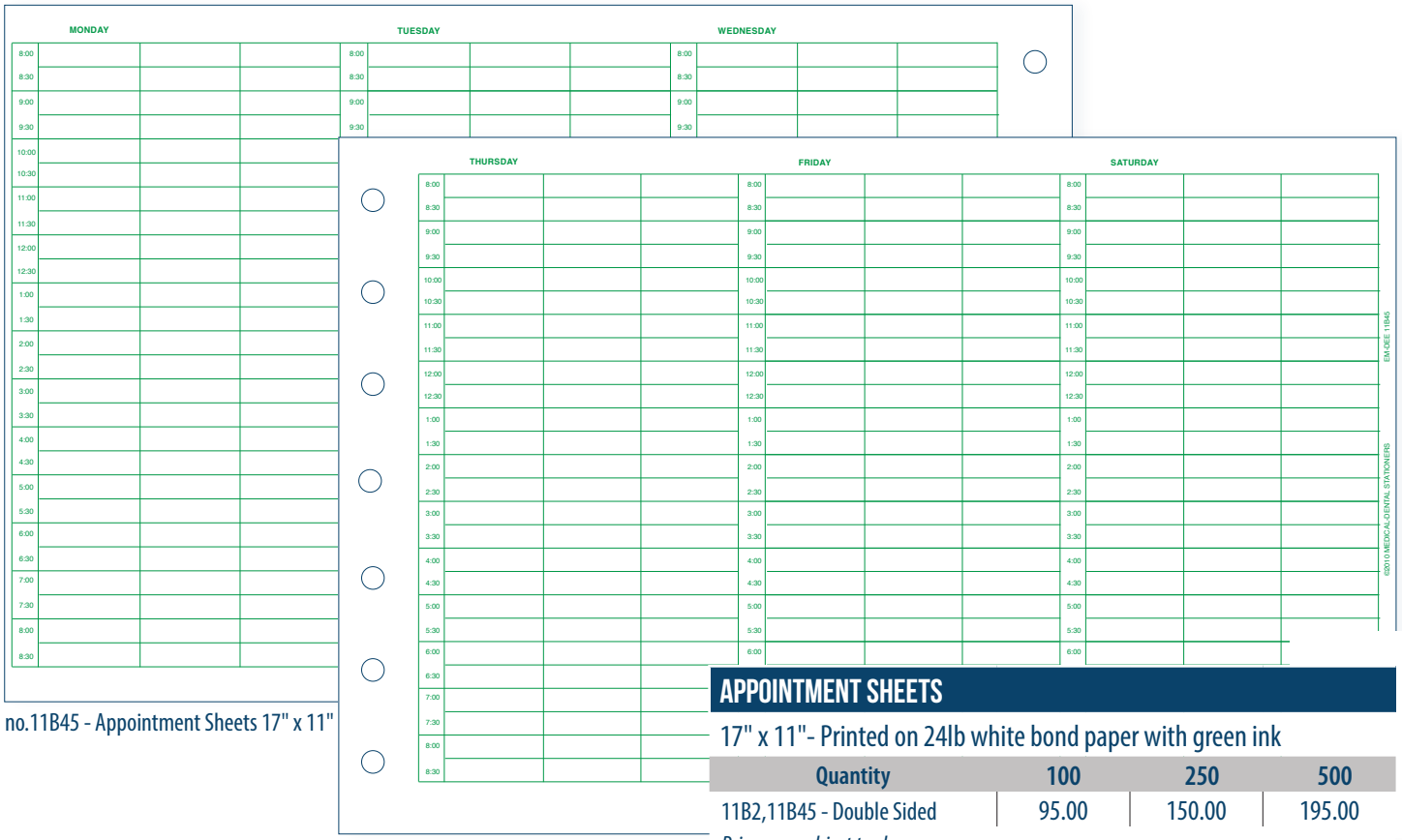
Quantity	250 Sets	500 Sets	1000 Sets	2000 Sets
2 Part NCR 125 Sets	125.00	145.00	193.00	285.00

Prices are subject to change.

APPOINTMENT SHEETS



no.11B2 - Appointment Sheets 17" x 11"



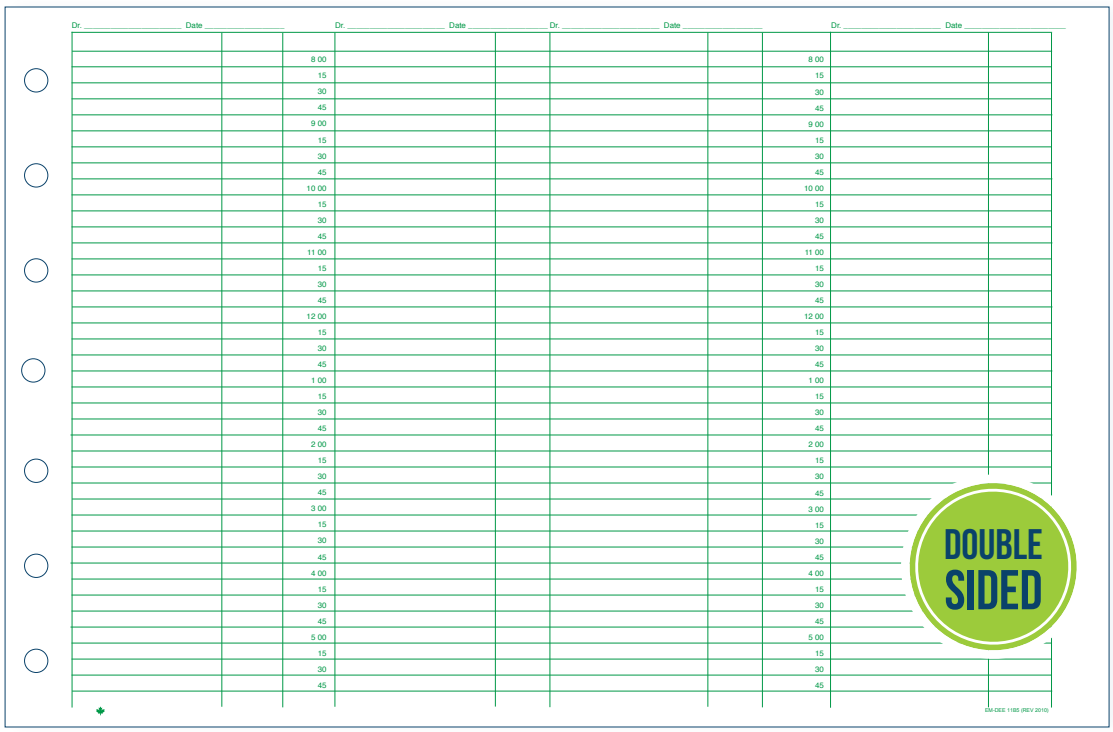
no.11B45 - Appointment Sheets 17" x 11"

APPOINTMENT SHEETS

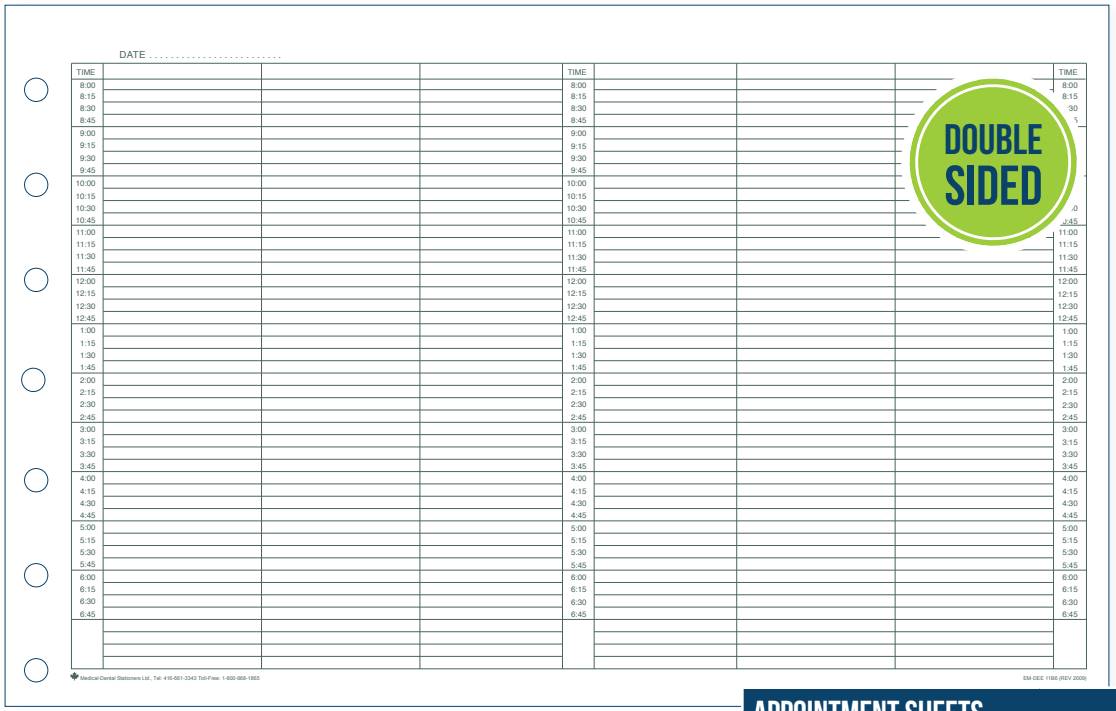
17" x 11"- Printed on 24lb white bond paper with green ink

Quantity	100	250	500
11B2,11B45 - Double Sided	95.00	150.00	195.00

Prices are subject to change



11B5 - Appointment Sheets 11" x 17"



11B6 - Appointment Sheets 11" x 17"

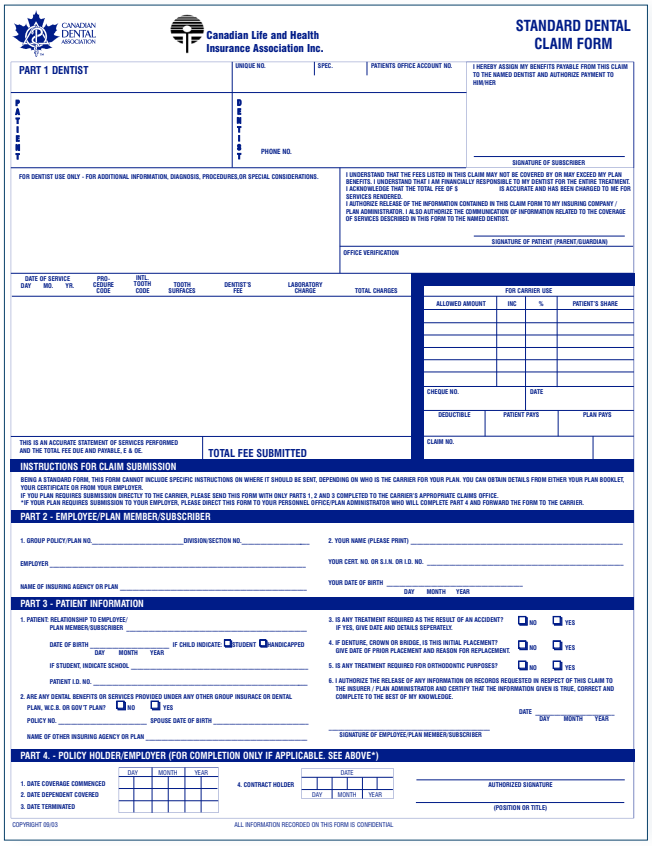
APPOINTMENT SHEETS

17" x 11"- Printed on 24lb white bond paper with green ink

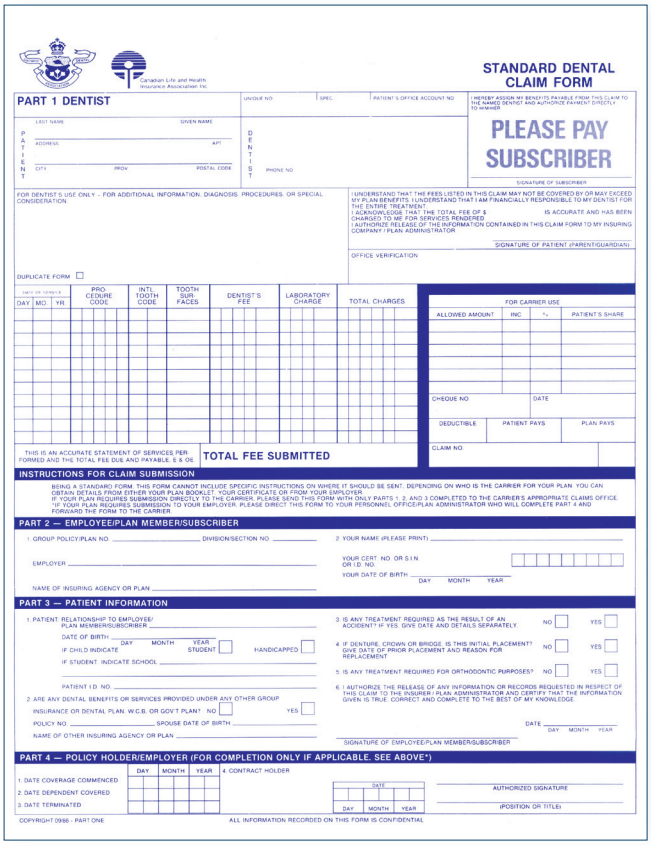
Quantity	100	250	500
11B5, 11B6 - Double Sided	95.00	150.00	195.00

Prices are subject to change

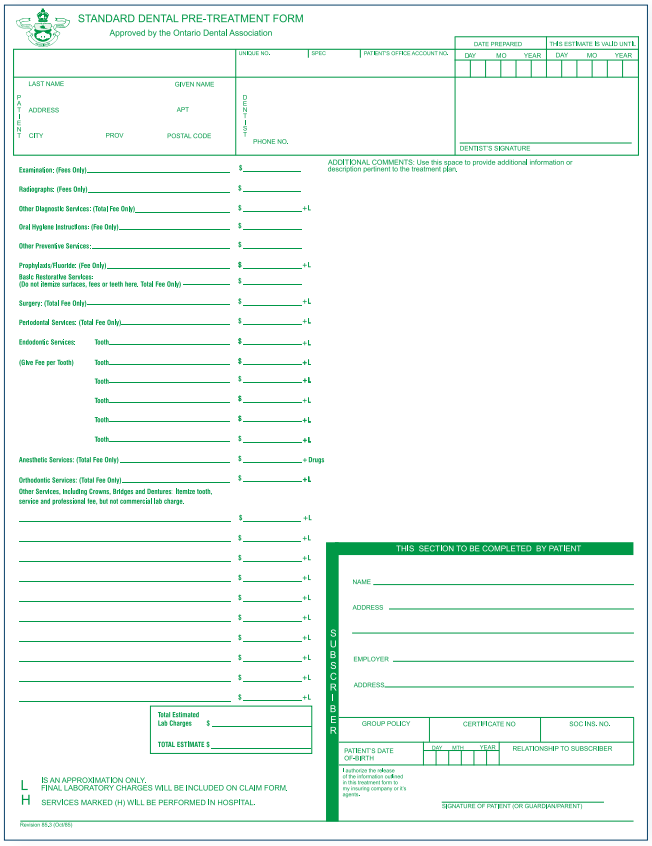
INSURANCE FORMS



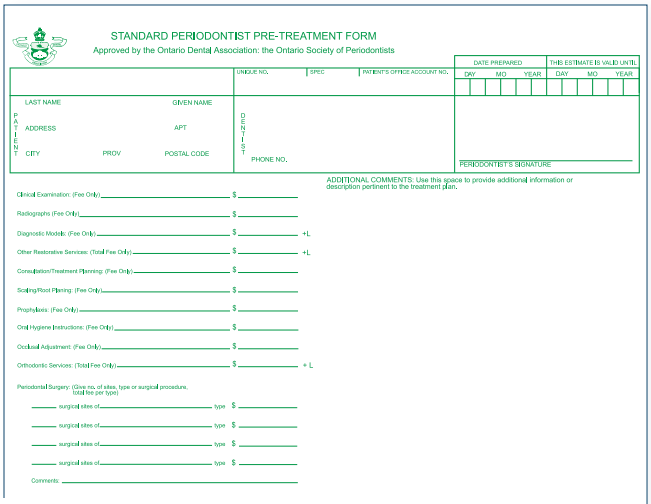
CDA Claim Form



ODA Claim Form



Pre Treatment Form

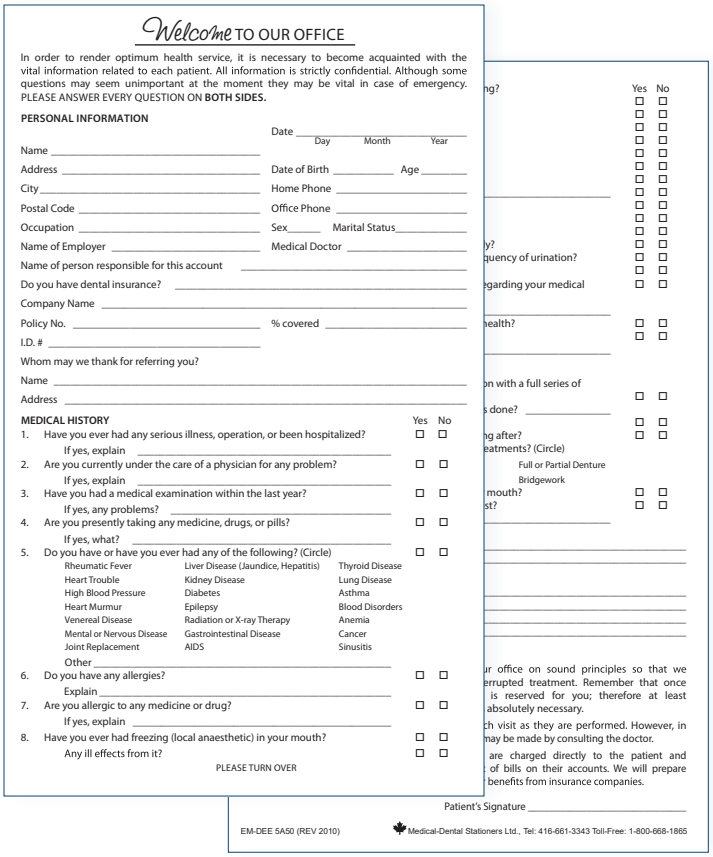


Standard Periodontist Pretreatment Form

INSURANCE FORMS

Quantity	250	500	1000	2000
Single Sheet - Blank	45.00	60.00	95.00	145.00
Single Sheet - Imprinted	129.00	140.00	175.00	225.00
2 Part Carbonless - Blank	78.00	105.00	180.00	320.00
2 Part Carbonless - Imprinted	150.00	205.00	270.00	445.00
3 Part Carbonless - Blank	115.00	135.00	245.00	475.00
3 Part Carbonless - Imprinted	175.00	235.00	350.00	605.00

Prices are subject to change



Welcome TO OUR OFFICE

In order to render optimum health service, it is necessary to become acquainted with the vital information related to each patient. All information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency. PLEASE ANSWER EVERY QUESTION ON **BOTH SIDES.**

PERSONAL INFORMATION

Date _____ (Day Month Year)

Name _____ Address _____ Date of Birth _____ Age _____

City _____ Home Phone _____

Postal Code _____ Office Phone _____

Occupation _____ Sex_____ Marital Status_____

Name of Employer _____ Medical Doctor _____

Name of person responsible for this account _____

Do you have dental insurance? _____

Company Name _____

Policy No. _____ % covered _____

I.D. # _____

Whom may we thank for referring you?

Name _____

Address _____

MEDICAL HISTORY Yes No

1. Have you ever had any serious illness, operation, or been hospitalized? ☐ ☐
   If yes, explain _____
2. Are you currently under the care of a physician for any problem? ☐ ☐
   If yes, explain _____
3. Have you had a medical examination within the last year? ☐ ☐
   If yes, any problems? _____
4. Are you presently taking any medicine, drugs, or pills? ☐ ☐
   If yes, what? _____
5. Do you have or have you ever had any of the following? (Circle) ☐ ☐

Rheumatic Fever	Liver Disease (Jaundice, Hepatitis)	Thyroid Disease
Heart Trouble	Kidney Disease	Lung Disease
High Blood Pressure	Diabetes	Asthma
Heart Murmur	Epilepsy	Blood Disorders
Venereal Disease	Radiation or X-ray Therapy	Anemia
Mental or Nervous Disease	Gastrointestinal Disease	Cancer
Joint Replacement	AIDS	Sinusitis

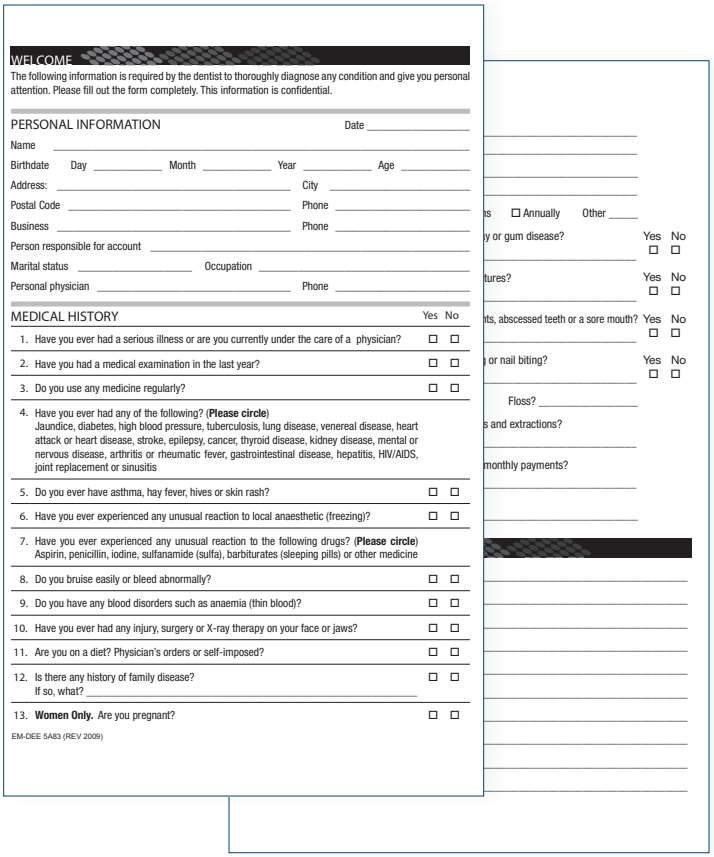
   Other _____
6. Do you have any allergies? ☐ ☐
   Explain _____
7. Are you allergic to any medicine or drug? ☐ ☐
   If yes, explain _____
8. Have you ever had freezing (local anaesthetic) in your mouth? ☐ ☐
   Any ill effects from it? ☐ ☐

PLEASE TURN OVER

Patient's Signature _____

EM-DEE 5A50 (REV 2010) Medical-Dental Stationers Ltd., Tel: 416-661-3343 Toll-Free: 1-800-668-1865

no. 5A50 - Form Health Questionnaire - 5" x 8", double-sided



WELCOME

The following information is required by the dentist to thoroughly diagnose any condition and give you personal attention. Please fill out the form completely. This information is confidential.

PERSONAL INFORMATION Date _____

Name _____

Birthdate Day _____ Month _____ Year _____ Age _____

Address: _____ City _____

Postal Code _____ Phone _____

Business _____ Phone _____

Person responsible for account _____

Marital status _____ Occupation _____

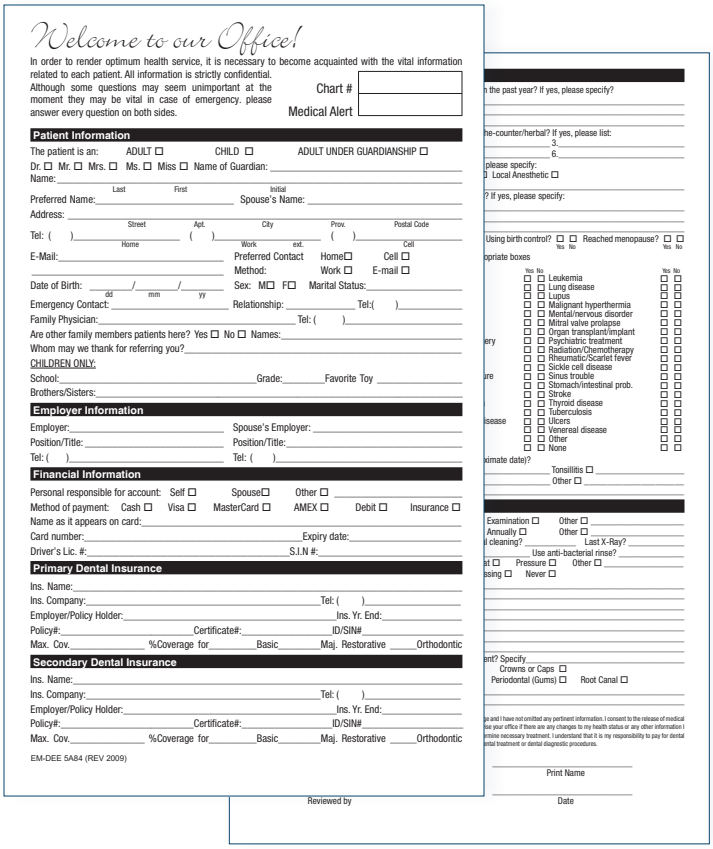
Personal physician _____ Phone _____

MEDICAL HISTORY Yes No

1. Have you ever had a serious illness or are you currently under the care of a physician? ☐ ☐
2. Have you had a medical examination in the last year? ☐ ☐
3. Do you use any medicine regularly? ☐ ☐
4. Have you ever had any of the following? (**Please circle**) Jaundice, diabetes, high blood pressure, tuberculosis, lung disease, venereal disease, heart attack or heart disease, stroke, epilepsy, cancer, thyroid disease, kidney disease, mental or nervous disease, arthritis or rheumatic fever, gastrointestinal disease, hepatitis, HIV/AIDS, joint replacement or sinusitis
5. Do you ever have asthma, hay fever, hives or skin rash? ☐ ☐
6. Have you ever experienced any unusual reaction to local anaesthetic (freezing)? ☐ ☐
7. Have you ever experienced any unusual reaction to the following drugs? (**Please circle**) Aspirin, penicillin, iodine, sulfanamide (sulfa), barbiturates (sleeping pills) or other medicine
8. Do you bruise easily or bleed abnormally? ☐ ☐
9. Do you have any blood disorders such as anaemia (thin blood)? ☐ ☐
10. Have you ever had any injury, surgery or X-ray therapy on your face or jaws? ☐ ☐
11. Are you on a diet? Physician's orders or self-imposed? ☐ ☐
12. Is there any history of family disease? ☐ ☐
    If so, what? _____
13. **Women Only.** Are you pregnant? ☐ ☐

EM-DEE 5A83 (REV 2009)

no. 5A83 - Health Questionnaire - 5" x 8", double-sided



Welcome to our Office!

In order to render optimum health service, it is necessary to become acquainted with the vital information related to each patient. All information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency. please answer every question on both sides.

Chart #

Medical Alert

Patient Information

The patient is an: ADULT ☐ CHILD ☐ ADULT UNDER GUARDIANSHIP ☐

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Name of Guardian: _____

Name: _____ (Last First Initial)

Preferred Name:_____ Spouse's Name: _____

Address: _____ (Street Apt. City Prov. Postal Code)

Tel: ( )_____ ( )_____ ( )_____ (Home Work ext. Cell)

E-Mail:_____ Preferred Contact Method: Home☐ Cell ☐ Work ☐ E-mail ☐

Date of Birth: ___/___/___ (dd mm yy) Sex: M☐ F☐ Marital Status:_____

Emergency Contact: _____ Relationship: _____ Tel:( )_____

Family Physician:_____ Tel: ( )_____

Are other family members patients here? Yes ☐ No ☐ Names:_____

Whom may we thank for referring you?_____

CHILDREN ONLY:

School:_____ Grade:_____ Favorite Toy _____

Brothers/Sisters:_____

Employer Information

Employer:_____ Spouse's Employer: _____

Position/Title: _____ Position/Title:_____

Tel: ( )_____ Tel: ( )_____

Financial Information

Personal responsible for account: Self ☐ Spouse☐ Other ☐ _____

Method of payment: Cash ☐ Visa ☐ MasterCard ☐ AMEX ☐ Debit ☐ Insurance ☐

Name as it appears on card:_____

Card number:_____ Expiry date:_____

Driver's Lic. #:_____ S.I.N #:_____

Primary Dental Insurance

Ins. Name:_____

Ins. Company:_____ Tel: ( )_____

Employer/Policy Holder:_____ Ins. Yr. End:_____

Policy#:_____ Certificate#:_____ ID/SIN#_____

Max. Cov._____ %Coverage for_____Basic_____Maj. Restorative _____Orthodontic

Secondary Dental Insurance

Ins. Name:_____

Ins. Company:_____ Tel: ( )_____

Employer/Policy Holder:_____ Ins. Yr. End:_____

Policy#:_____ Certificate#:_____ ID/SIN#_____

Max. Cov._____ %Coverage for_____Basic_____Maj. Restorative _____Orthodontic

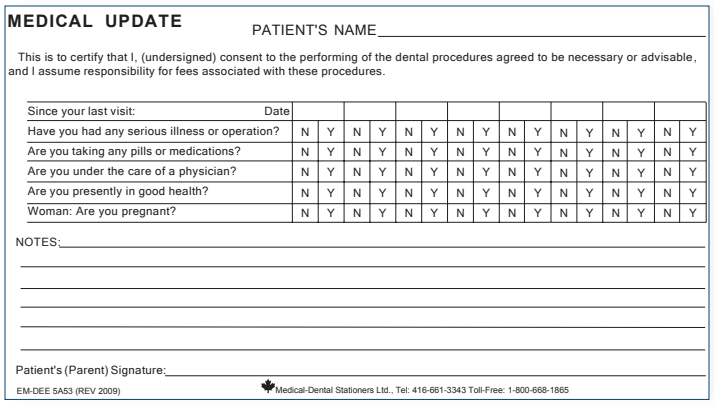
EM-DEE 5A84 (REV 2009)

Reviewed by

Print Name

Date

no. 5A84 - Health Questionnaire - 5" x 8", double-sided



MEDICAL UPDATE PATIENT'S NAME_____

This is to certify that I, (undersigned) consent to the performing of the dental procedures agreed to be necessary or advisable, and I assume responsibility for fees associated with these procedures.

Since your last visit: Date															
Have you had any serious illness or operation?	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y
Are you taking any pills or medications?	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y
Are you under the care of a physician?	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y
Are you presently in good health?	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y
Woman: Are you pregnant?	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y

NOTES:_____

Patient's (Parent) Signature:_____

EM-DEE 5A53 (REV 2009) Medical-Dental Stationers Ltd., Tel: 416-661-3343 Toll-Free: 1-800-668-1865

no. 5A53 - Medical Update Form - 7" x 4", single-sided

yellow	ivory	salmon
green	blue	cherry

MAKE YOUR CHARTS **STAND OUT BY PRINTING THEM ON COLOURED STOCK**

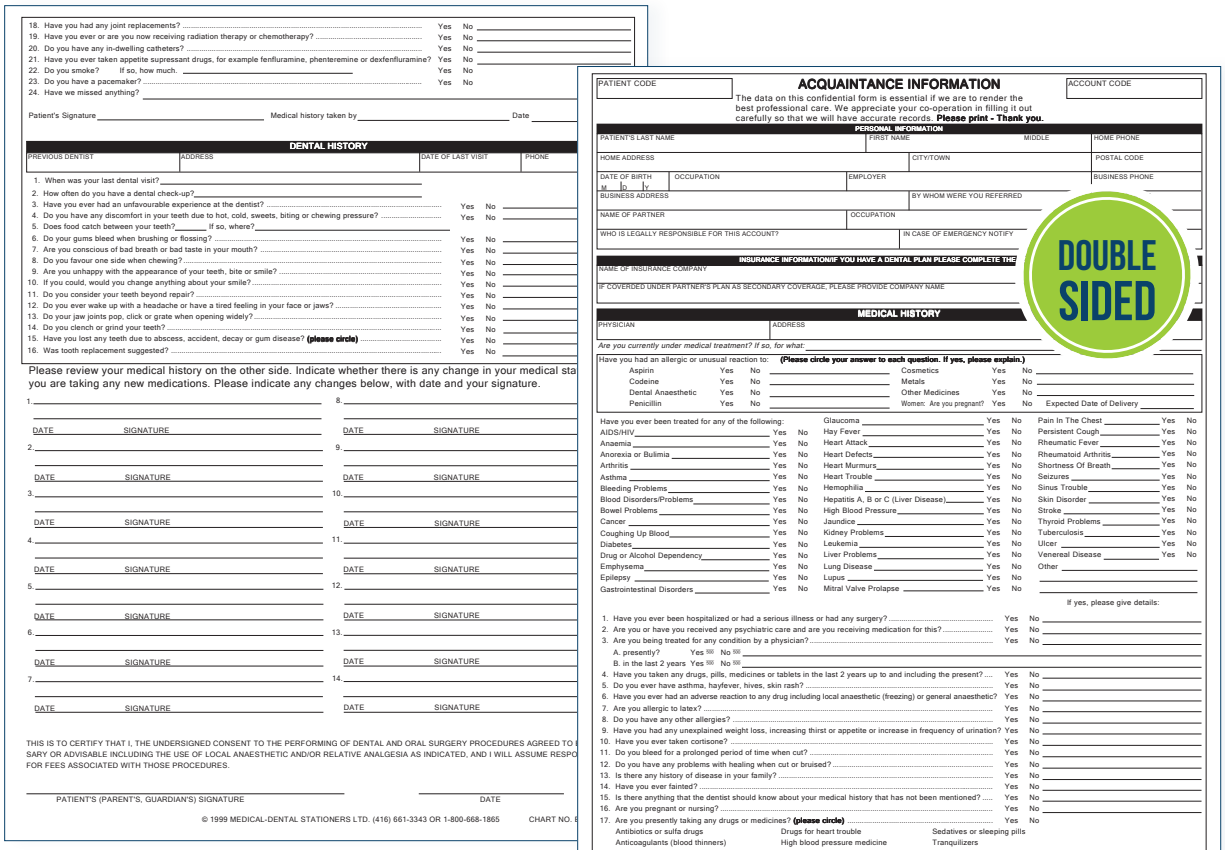
HEALTH / HISTORY QUESTIONNAIRES

5" x 8" - Printed on 110lb white chart stock with black ink

Quantity	250	500	1000	2000
5" x 8" Cards	77.00	105.00	140.00	225.00
5" x 8" Cards DS	77.00	105.00	140.00	225.00
Medical Update 7" x 4"	70.00	95.00	130.00	190.00

Coloured stock available at extra charge. Prices are subject to change.

HEALTH HISTORY QUESTIONNAIRES • 8.5 X 11



DENTAL HISTORY

PREVIOUS DENTIST | ADDRESS | DATE OF LAST VISIT | PHONE

1. When was your last dental visit?
2. How often do you have a dental check-up?
3. Have you ever had an unfavourable experience at the dentist? Yes No
4. Do you have any discomfort in your teeth due to hot, cold, sweets, biting or chewing pressure? Yes No
5. Does food catch between your teeth? If so, where?
6. Do your gums bleed when brushing or flossing? Yes No
7. Are you conscious of bad breath or bad taste in your mouth? Yes No
8. Do you favour one side when chewing? Yes No
9. Are you unhappy with the appearance of your teeth, bite or smile? Yes No
10. If you could, would you change anything about your smile? Yes No
11. Do you consider your teeth beyond repair? Yes No
12. Do you ever wake up with a headache or have a tired feeling in your face or jaws? Yes No
13. Do your jaw joints pop, click or grate when opening widely? Yes No
14. Do you clench or grind your teeth? Yes No
15. Have you lost any teeth due to abscess, accident, decay or gum disease? **(please circle)** Yes No
16. Was tooth replacement suggested? Yes No

Please review your medical history on the other side. Indicate whether there is any change in your medical sta
you are taking any new medications. Please indicate any changes below, with date and your signature.

DATE SIGNATURE

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED CONSENT TO THE PERFORMING OF DENTAL AND ORAL SURGERY PROCEDURES AGREED TO
SARY OR ADVISABLE INCLUDING THE USE OF LOCAL ANAESTHETIC AND/OR RELATIVE ANALGESIA AS INDICATED, AND I WILL ASSUME RESPO
FOR FEES ASSOCIATED WITH THOSE PROCEDURES.

PATIENT'S (PARENT'S, GUARDIAN'S) SIGNATURE DATE

 CHART NO.

ACQUAINTANCE INFORMATION

PATIENT CODE | ACCOUNT CODE

The data on this confidential form is essential if we are to render the best professional care. We appreciate your co-operation in filling it out carefully so that we will have accurate records. **Please print - Thank you.**

PERSONAL INFORMATION

PATIENT'S LAST NAME | FIRST NAME | MIDDLE | HOME PHONE
HOME ADDRESS | CITY/TOWN | POSTAL CODE
DATE OF BIRTH M D Y | OCCUPATION | EMPLOYER | BUSINESS PHONE
BUSINESS ADDRESS | BY WHOM WERE YOU REFERRED
NAME OF PARTNER | OCCUPATION
WHO IS LEGALLY RESPONSIBLE FOR THIS ACCOUNT? | IN CASE OF EMERGENCY NOTIFY

INSURANCE INFORMATION/IF YOU HAVE A DENTAL PLAN PLEASE COMPLETE THE
NAME OF INSURANCE COMPANY
IF COVERDED UNDER PARTNER'S PLAN AS SECONDARY COVERAGE, PLEASE PROVIDE COMPANY NAME

MEDICAL HISTORY

PHYSICIAN | ADDRESS

Are you currently under medical treatment? If so, for what:

Have you had an allergic or unusual reaction to: **(Please circle your answer to each question. If yes, please explain.)**

Aspirin Yes No | Cosmetics Yes No
Codeine Yes No | Metals Yes No
Dental Anaesthetic Yes No | Other Medicines Yes No
Penicillin Yes No | Women: Are you pregnant? Yes No Expected Date of Delivery

Have you ever been treated for any of the following:

AIDS/HIV Yes No | Glaucoma Yes No | Pain In The Chest Yes No
Anaemia Yes No | Hay Fever Yes No | Persistent Cough Yes No
Anorexia or Bulimia Yes No | Heart Attack Yes No | Rheumatic Fever Yes No
Arthritis Yes No | Heart Defects Yes No | Rheumatoid Arthritis Yes No
Asthma Yes No | Heart Murmurs Yes No | Shortness Of Breath Yes No
Bleeding Problems Yes No | Heart Trouble Yes No | Seizures Yes No
Blood Disorders/Problems Yes No | Hemophilia Yes No | Sinus Trouble Yes No
Bowel Problems Yes No | Hepatitis A, B or C (Liver Disease) Yes No | Skin Disorder Yes No
Cancer Yes No | High Blood Pressure Yes No | Stroke Yes No
Coughing Up Blood Yes No | Jaundice Yes No | Thyroid Problems Yes No
Diabetes Yes No | Kidney Problems Yes No | Tuberculosis Yes No
Drug or Alcohol Dependency Yes No | Leukemia Yes No | Ulcer Yes No
Emphysema Yes No | Liver Problems Yes No | Venereal Disease Yes No
Epilepsy Yes No | Lung Disease Yes No | Other
Gastrointestinal Disorders Yes No | Lupus Yes No
Mitral Valve Prolapse Yes No

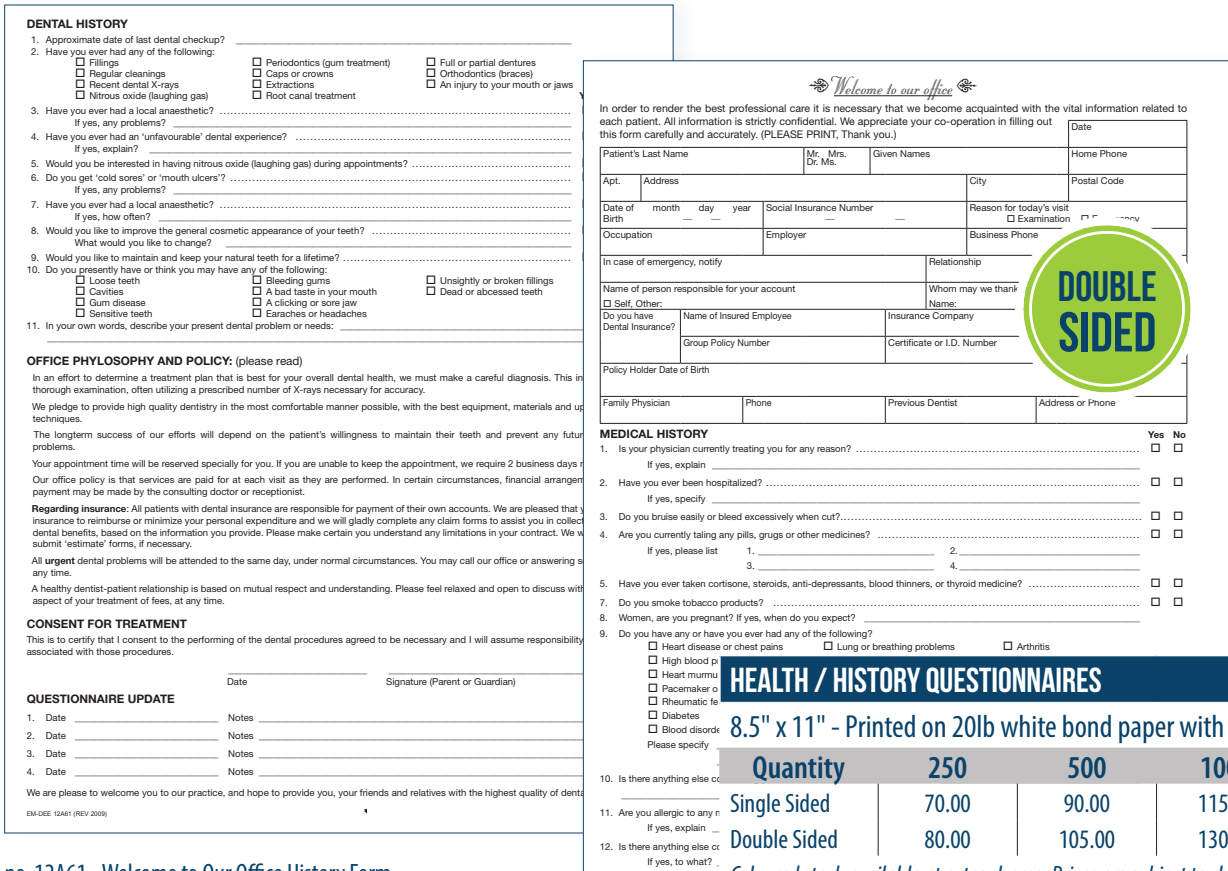
If yes, please give details:

1. Have you ever been hospitalized or had a serious illness or had any surgery? Yes No
2. Are you or have you received any psychiatric care and are you receiving medication for this? Yes No
3. Are you being treated for any condition by a physician? Yes No
   A. presently? Yes No
   B. in the last 2 years Yes No
4. Have you taken any drugs, pills, medicines or tablets in the last 2 years up to and including the present? Yes No
5. Do you ever have asthma, hayfever, hives, skin rash? Yes No
6. Have you ever had an adverse reaction to any drug including local anaesthetic (freezing) or general anaesthetic? Yes No
7. Are you allergic to latex? Yes No
8. Do you have any other allergies? Yes No
9. Have you had any unexplained weight loss, increasing thirst or appetite or increase in frequency of urination? Yes No
10. Have you ever taken cortisone? Yes No
11. Do you bleed for a prolonged period of time when cut? Yes No
12. Do you have any problems with healing when cut or bruised? Yes No
13. Is there any history of disease in your family? Yes No
14. Have you ever fainted? Yes No
15. Is there anything that the dentist should know about your medical history that has not been mentioned? Yes No
16. Are you pregnant or nursing? Yes No
17. Are you presently taking any drugs or medicines? **(please circle)** Yes No

Antibiotics or sulfa drugs | Drugs for heart trouble | Sedatives or sleeping pills
Anticoagulants (blood thinners) | High blood pressure medicine | Tranquilizers
Antidepressants | Insulin, Diabinese or similar drug | Water pills
Cortisone | Nitroglycerin | Other

DOUBLE SIDED

no. 12A58 - Welcome to Our Office History Form



DENTAL HISTORY

1. Approximate date of last dental checkup?
2. Have you ever had any of the following:
   - ☐ Fillings
   - ☐ Regular cleanings
   - ☐ Recent dental X-rays
   - ☐ Nitrous oxide (laughing gas)
   - ☐ Periodontics (gum treatment)
   - ☐ Caps or crowns
   - ☐ Extractions
   - ☐ Root canal treatment
   - ☐ Full or partial dentures
   - ☐ Orthodontics (braces)
   - ☐ An injury to your mouth or jaws
3. Have you ever had a local anaesthetic? If yes, any problems?
4. Have you ever had an 'unfavourable' dental experience? If yes, explain?
5. Would you be interested in having nitrous oxide (laughing gas) during appointments?
6. Do you get 'cold sores' or 'mouth ulcers'? If yes, any problems?
7. Have you ever had a local anaesthetic? If yes, how often?
8. Would you like to improve the general cosmetic appearance of your teeth? What would you like to change?
9. Would you like to maintain and keep your natural teeth for a lifetime?
10. Do you presently have or think you may have any of the following:
    - ☐ Loose teeth
    - ☐ Cavities
    - ☐ Gum disease
    - ☐ Sensitive teeth
    - ☐ Bleeding gums
    - ☐ A bad taste in your mouth
    - ☐ A clicking or sore jaw
    - ☐ Earaches or headaches
    - ☐ Unsightly or broken fillings
    - ☐ Dead or abcessed teeth
11. In your own words, describe your present dental problem or needs:

OFFICE PHYLOSOPHY AND POLICY: (please read)

In an effort to determine a treatment plan that is best for your overall dental health, we must make a careful diagnosis. This in thorough examination, often utilizing a prescribed number of X-rays necessary for accuracy.

We pledge to provide high quality dentistry in the most comfortable manner possible, with the best equipment, materials and up techniques.

The longterm success of our efforts will depend on the patient's willingness to maintain their teeth and prevent any futur problems.

Your appointment time will be reserved specially for you. If you are unable to keep the appointment, we require 2 business days r

Our office policy is that services are paid for at each visit as they are performed. In certain circumstances, financial arrangen payment may be made by the consulting doctor or receptionist.

Regarding insurance: All patients with dental insurance are responsible for payment of their own accounts. We are pleased that y insurance to reimburse or minimize your personal expenditure and we will gladly complete any claim forms to assist you in collec dental benefits, based on the information you provide. Please make certain you understand any limitations in your contract. We w submit 'estimate' forms, if necessary.

All **urgent** dental problems will be attended to the same day, under normal circumstances. You may call our office or answering s any time.

A healthy dentist-patient relationship is based on mutual respect and understanding. Please feel relaxed and open to discuss with aspect of your treatment of fees, at any time.

CONSENT FOR TREATMENT

This is to certify that I consent to the performing of the dental procedures agreed to be necessary and I will assume responsibility associated with those procedures.

Date Signature (Parent or Guardian)

QUESTIONNAIRE UPDATE

1. Date Notes
2. Date Notes
3. Date Notes
4. Date Notes

We are please to welcome you to our practice, and hope to provide you, your friends and relatives with the highest quality of denta

EM-DEE 12A61 (REV 2009)

Welcome to our office

In order to render the best professional care it is necessary that we become acquainted with the vital information related to each patient. All information is strictly confidential. We appreciate your co-operation in filling out this form carefully and accurately. (PLEASE PRINT, Thank you.)

Date

Patient's Last Name | Mr. Mrs. Dr. Ms. | Given Names | Home Phone
Apt. | Address | City | Postal Code
Date of Birth month day year | Social Insurance Number | Reason for today's visit ☐ Examination
Occupation | Employer | Business Phone
In case of emergency, notify | Relationship
Name of person responsible for your account | Whom may we thank
☐ Self, Other: | Name:
Do you have Dental Insurance? | Name of Insured Employee | Insurance Company
Group Policy Number | Certificate or I.D. Number
Policy Holder Date of Birth
Family Physician | Phone | Previous Dentist | Address or Phone

DOUBLE SIDED

MEDICAL HISTORY

Yes No

1. Is your physician currently treating you for any reason? If yes, explain
2. Have you ever been hospitalized? If yes, specify
3. Do you bruise easily or bleed excessively when cut?
4. Are you currently taling any pills, grugs or other medicines? If yes, please list 1. 2. 3. 4.
5. Have you ever taken cortisone, steroids, anti-depressants, blood thinners, or thyroid medicine?
7. Do you smoke tobacco products?
8. Women, are you pregnant? If yes, when do you expect?
9. Do you have any or have you ever had any of the following?
   - ☐ Heart disease or chest pains
   - ☐ Lung or breathing problems
   - ☐ Arthritis
   - ☐ High blood p
   - ☐ Heart murmu
   - ☐ Pacemaker o
   - ☐ Rheumatic fe
   - ☐ Diabetes
   - ☐ Blood disorde

   Please specify
10. Is there anything else c
11. Are you allergic to any n If yes, explain
12. Is there anything else c If yes, to what?

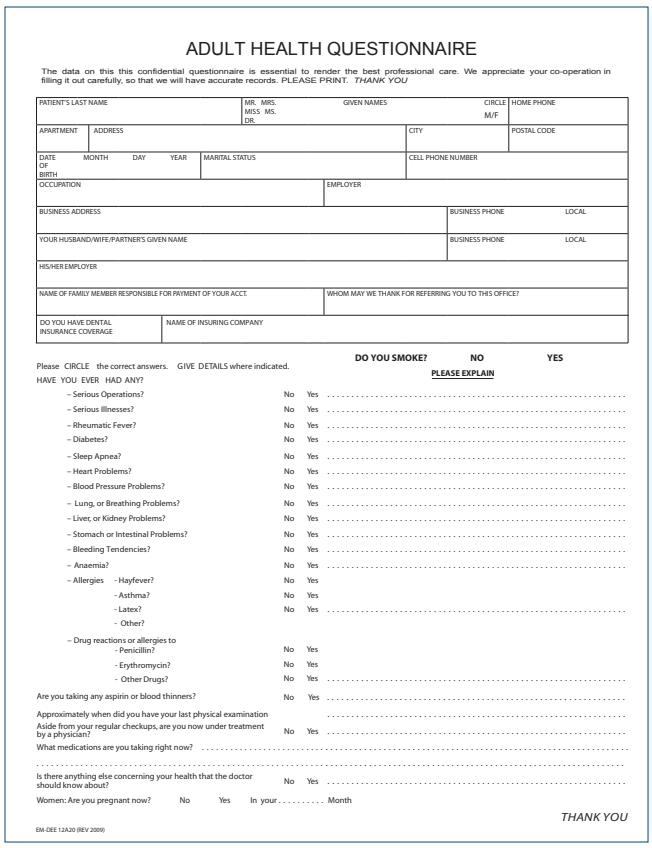
no. 12A61 - Welcome to Our Office History Form

HEALTH / HISTORY QUESTIONNAIRES

8.5" x 11" - Printed on 20lb white bond paper with black ink

Quantity	250	500	1000	2000
Single Sided	70.00	90.00	115.00	170.00
Double Sided	80.00	105.00	130.00	185.00

Coloured stock available at extra charge. Prices are subject to change.



ADULT HEALTH QUESTIONNAIRE

The data on this this confidential questionnaire is essential to render the best professional care. We appreciate your co-operation in filling it out carefully, so that we will have accurate records. PLEASE PRINT. *THANK YOU*

PATIENT'S LAST NAME | MR. MRS. MISS MS. DR. | GIVEN NAMES | CIRCLE M/F | HOME PHONE

APARTMENT | ADDRESS | CITY | POSTAL CODE

DATE OF BIRTH MONTH DAY YEAR | MARITAL STATUS | CELL PHONE NUMBER

OCCUPATION | EMPLOYER

BUSINESS ADDRESS | BUSINESS PHONE LOCAL

YOUR HUSBAND/WIFE/PARTNER'S GIVEN NAME | BUSINESS PHONE LOCAL

HIS/HER EMPLOYER

NAME OF FAMILY MEMBER RESPONSIBLE FOR PAYMENT OF YOUR ACCT. | WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?

DO YOU HAVE DENTAL INSURANCE COVERAGE | NAME OF INSURING COMPANY

DO YOU SMOKE? NO YES

Please CIRCLE the correct answers. GIVE DETAILS where indicated. PLEASE EXPLAIN

HAVE YOU EVER HAD ANY?

- Serious Operations? No Yes
- Serious Illnesses? No Yes
- Rheumatic Fever? No Yes
- Diabetes? No Yes
- Sleep Apnea? No Yes
- Heart Problems? No Yes
- Blood Pressure Problems? No Yes
- Lung, or Breathing Problems? No Yes
- Liver, or Kidney Problems? No Yes
- Stomach or Intestinal Problems? No Yes
- Bleeding Tendencies? No Yes
- Anaemia? No Yes
- Allergies - Hayfever? No Yes
  - Asthma? No Yes
  - Latex? No Yes
  - Other?
- Drug reactions or allergies to
  - Penicillin? No Yes
  - Erythromycin? No Yes
  - Other Drugs? No Yes

Are you taking any aspirin or blood thinners? No Yes

Approximately when did you have your last physical examination

Aside from your regular checkups, are you now under treatment by a physician? No Yes

What medications are you taking right now?

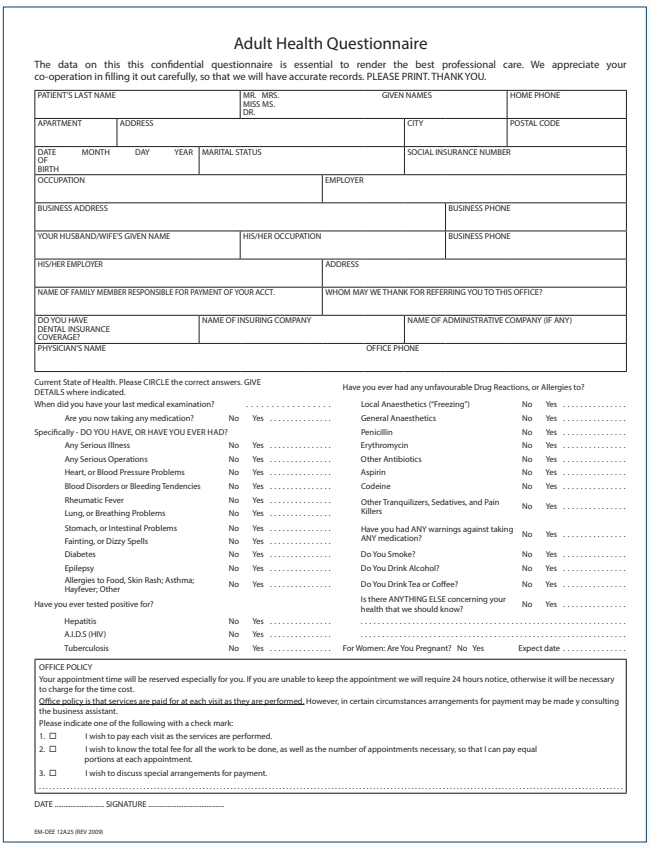
Is there anything else concerning your health that the doctor should know about? No Yes

Women: Are you pregnant now? No Yes In your ..... Month

THANK YOU

EM-DEE 12A20 (REV 2009)

no. 12A20 - Adult Health Questionnaire



Adult Health Questionnaire

The data on this this confidential questionnaire is essential to render the best professional care. We appreciate your co-operation in filling it out carefully, so that we will have accurate records. PLEASE PRINT. THANK YOU.

PATIENT'S LAST NAME | MR. MRS. MISS MS. DR. | GIVEN NAMES | HOME PHONE

APARTMENT | ADDRESS | CITY | POSTAL CODE

DATE OF BIRTH MONTH DAY YEAR | MARITAL STATUS | SOCIAL INSURANCE NUMBER

OCCUPATION | EMPLOYER

BUSINESS ADDRESS | BUSINESS PHONE

YOUR HUSBAND/WIFE'S GIVEN NAME | HIS/HER OCCUPATION | BUSINESS PHONE

HIS/HER EMPLOYER | ADDRESS

NAME OF FAMILY MEMBER RESPONSIBLE FOR PAYMENT OF YOUR ACCT. | WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?

DO YOU HAVE DENTAL INSURANCE COVERAGE? | NAME OF INSURING COMPANY | NAME OF ADMINISTRATIVE COMPANY (IF ANY)

PHYSICIAN'S NAME | OFFICE PHONE

Current State of Health. Please CIRCLE the correct answers. GIVE DETAILS where indicated.

When did you have your last medical examination? .....

Are you now taking any medication? No Yes .....

Specifically - DO YOU HAVE, OR HAVE YOU EVER HAD?

- Any Serious Illness No Yes .....
- Any Serious Operations No Yes .....
- Heart, or Blood Pressure Problems No Yes .....
- Blood Disorders or Bleeding Tendencies No Yes .....
- Rheumatic Fever No Yes .....
- Lung, or Breathing Problems No Yes .....
- Stomach, or Intestinal Problems No Yes .....
- Fainting, or Dizzy Spells No Yes .....
- Diabetes No Yes .....
- Epilepsy No Yes .....
- Allergies to Food, Skin Rash; Asthma; Hayfever; Other No Yes .....

Have you ever tested positive for?

- Hepatitis No Yes .....
- A.I.D.S (HIV) No Yes .....
- Tuberculosis No Yes .....

Have you ever had any unfavourable Drug Reactions, or Allergies to?

- Local Anaesthetics ("Freezing") No Yes .....
- General Anaesthetics No Yes .....
- Penicillin No Yes .....
- Erythromycin No Yes .....
- Other Antibiotics No Yes .....
- Aspirin No Yes .....
- Codeine No Yes .....
- Other Tranquilizers, Sedatives, and Pain Killers No Yes .....
- Have you had ANY warnings against taking ANY medication? No Yes .....
- Do You Smoke? No Yes .....
- Do You Drink Alcohol? No Yes .....
- Do You Drink Tea or Coffee? No Yes .....
- Is there ANYTHING ELSE concerning your health that we should know? No Yes .....

For Women: Are You Pregnant? No Yes Expect date .....

OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 24 hours notice, otherwise it will be necessary to charge for the time cost.

Office policy is that services are paid for at each visit as they are performed. However, in certain circumstances arrangements for payment may be made y consulting the business assistant.

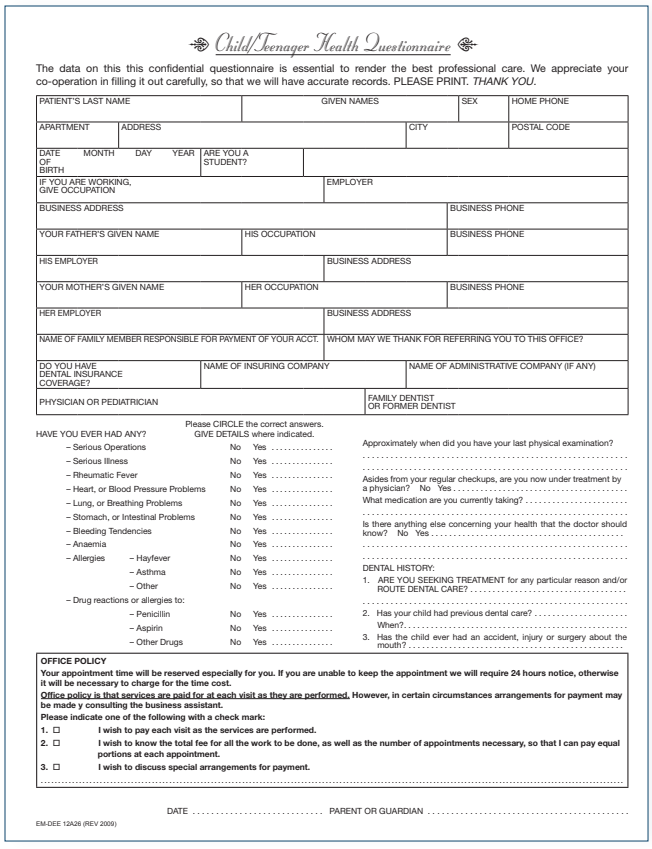
Please indicate one of the following with a check mark:

1. ☐ I wish to pay each visit as the services are performed.
2. ☐ I wish to know the total fee for all the work to be done, as well as the number of appointments necessary, so that I can pay equal portions at each appointment.
3. ☐ I wish to discuss special arrangements for payment.

DATE ..... SIGNATURE .....

EM-DEE 12A25 (REV 2009)

no. 12A25 - Adult Health Questionnaire



Child/Teenager Health Questionnaire

The data on this this confidential questionnaire is essential to render the best professional care. We appreciate your co-operation in filling it out carefully, so that we will have accurate records. PLEASE PRINT. *THANK YOU.*

PATIENT'S LAST NAME | GIVEN NAMES | SEX | HOME PHONE

APARTMENT | ADDRESS | CITY | POSTAL CODE

DATE OF BIRTH MONTH DAY YEAR | ARE YOU A STUDENT?

IF YOU ARE WORKING, GIVE OCCUPATION | EMPLOYER

BUSINESS ADDRESS | BUSINESS PHONE

YOUR FATHER'S GIVEN NAME | HIS OCCUPATION | BUSINESS PHONE

HIS EMPLOYER | BUSINESS ADDRESS

YOUR MOTHER'S GIVEN NAME | HER OCCUPATION | BUSINESS PHONE

HER EMPLOYER | BUSINESS ADDRESS

NAME OF FAMILY MEMBER RESPONSIBLE FOR PAYMENT OF YOUR ACCT. | WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?

DO YOU HAVE DENTAL INSURANCE COVERAGE? | NAME OF INSURING COMPANY | NAME OF ADMINISTRATIVE COMPANY (IF ANY)

PHYSICIAN OR PEDIATRICIAN | FAMILY DENTIST OR FORMER DENTIST

Please CIRCLE the correct answers. GIVE DETAILS where indicated.

HAVE YOU EVER HAD ANY?

- Serious Operations No Yes .....
- Serious Illness No Yes .....
- Rheumatic Fever No Yes .....
- Heart, or Blood Pressure Problems No Yes .....
- Lung, or Breathing Problems No Yes .....
- Stomach, or Intestinal Problems No Yes .....
- Bleeding Tendencies No Yes .....
- Anaemia No Yes .....
- Allergies – Hayfever No Yes .....
  - Asthma No Yes .....
  - Other No Yes .....
- Drug reactions or allergies to:
  - Penicillin No Yes .....
  - Aspirin No Yes .....
  - Other Drugs No Yes .....

Approximately when did you have your last physical examination?

Asides from your regular checkups, are you now under treatment by a physician? No Yes .....

What medication are you currently taking?

Is there anything else concerning your health that the doctor should know? No Yes .....

DENTAL HISTORY:

1. ARE YOU SEEKING TREATMENT for any particular reason and/or ROUTE DENTAL CARE? .....
2. Has your child had previous dental care? ..... When?.....
3. Has the child ever had an accident, injury or surgery about the mouth? .....

OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 24 hours notice, otherwise it will be necessary to charge for the time cost.

Office policy is that services are paid for at each visit as they are performed. However, in certain circumstances arrangements for payment may be made y consulting the business assistant.

Please indicate one of the following with a check mark:

1. ☐ I wish to pay each visit as the services are performed.

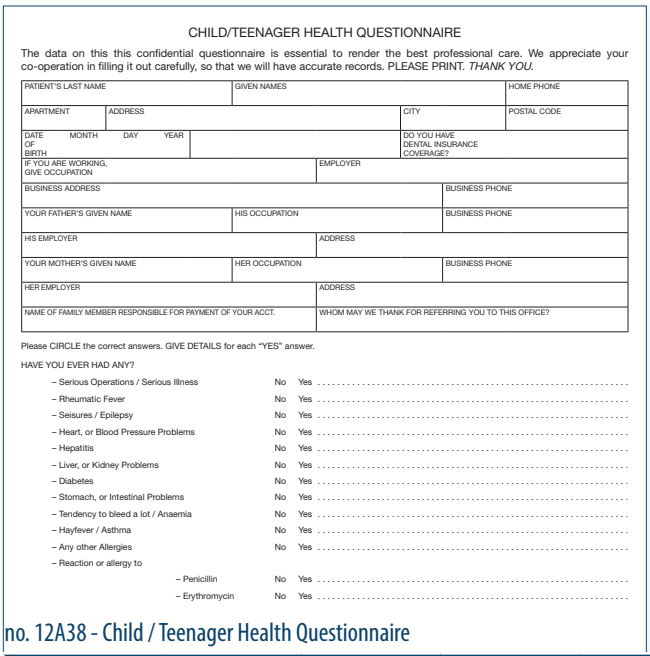
2. ☐ I wish to know the total fee for all the work to be done, as well as the number of appointments necessary, so that I can pay equal portions at each appointment.

3. ☐ I wish to discuss special arrangements for payment.

DATE ..... PARENT OR GUARDIAN .....

EM-DEE 12A26 (REV 2009)

no. 12A26 - Adult Health Questionnaire



CHILD/TEENAGER HEALTH QUESTIONNAIRE

The data on this this confidential questionnaire is essential to render the best professional care. We appreciate your co-operation in filling it out carefully, so that we will have accurate records. PLEASE PRINT. *THANK YOU.*

PATIENT'S LAST NAME | GIVEN NAMES | HOME PHONE

APARTMENT | ADDRESS | CITY | POSTAL CODE

DATE OF BIRTH MONTH DAY YEAR | DO YOU HAVE DENTAL INSURANCE COVERAGE?

IF YOU ARE WORKING, GIVE OCCUPATION | EMPLOYER

BUSINESS ADDRESS | BUSINESS PHONE

YOUR FATHER'S GIVEN NAME | HIS OCCUPATION | BUSINESS PHONE

HIS EMPLOYER | ADDRESS

YOUR MOTHER'S GIVEN NAME | HER OCCUPATION | BUSINESS PHONE

HER EMPLOYER | ADDRESS

NAME OF FAMILY MEMBER RESPONSIBLE FOR PAYMENT OF YOUR ACCT. | WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?

Please CIRCLE the correct answers. GIVE DETAILS for each "YES" answer.

HAVE YOU EVER HAD ANY?

- Serious Operations / Serious Illness No Yes .....
- Rheumatic Fever No Yes .....
- Seisures / Epilepsy No Yes .....
- Heart, or Blood Pressure Problems No Yes .....
- Hepatitis No Yes .....
- Liver, or Kidney Problems No Yes .....
- Diabetes No Yes .....
- Stomach, or Intestinal Problems No Yes .....
- Tendency to bleed a lot / Anaemia No Yes .....
- Hayfever / Asthma No Yes .....
- Any other Allergies No Yes .....
- Reaction or allergy to
  - Penicillin No Yes .....
  - Erythromycin No Yes .....

no. 12A38 - Child / Teenager Health Questionnaire

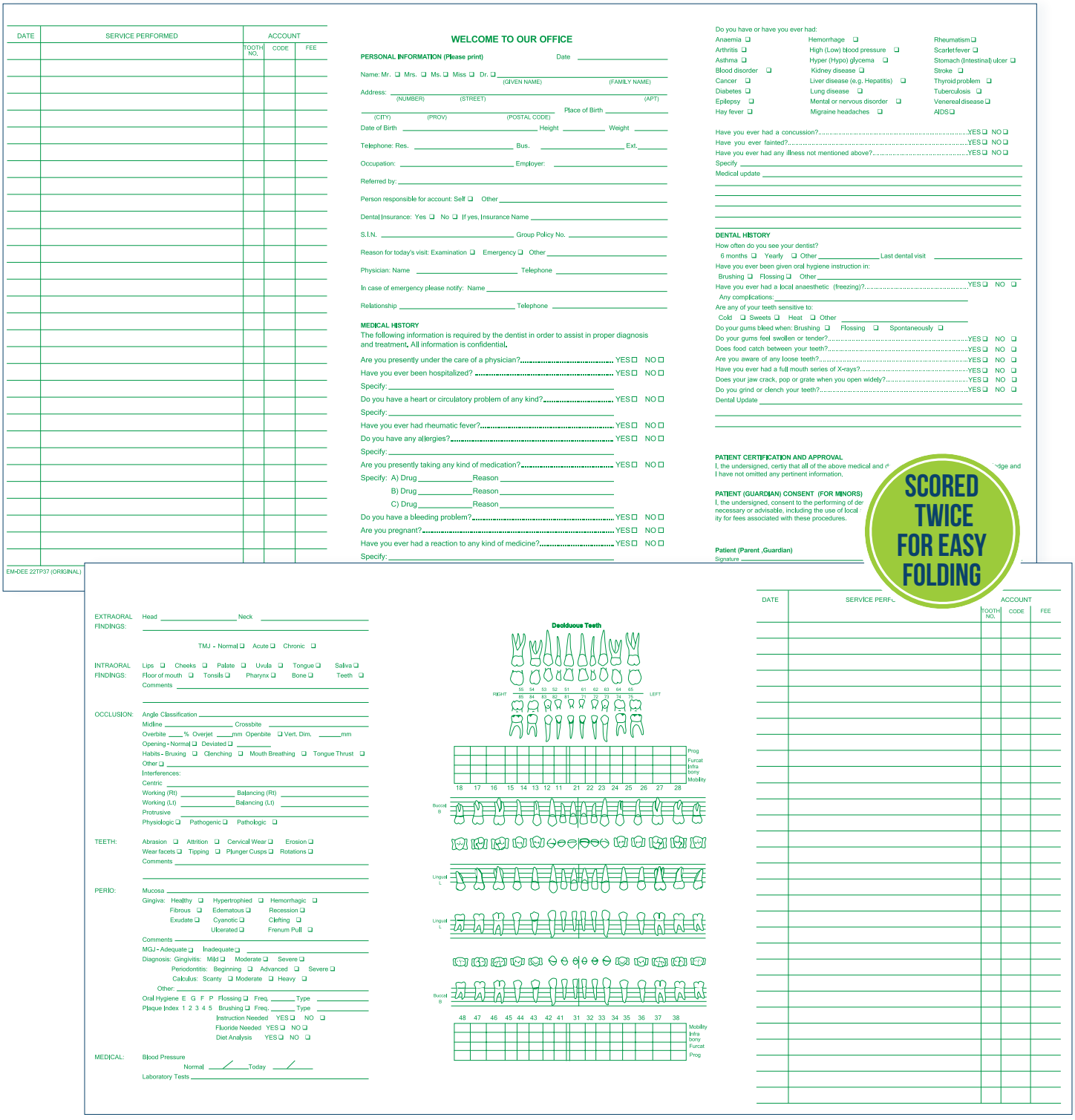
HEALTH / HISTORY QUESTIONNAIRES

8.5" x 11" - Printed on 20lb white bond paper with black ink

Quantity	250	500	1000	2000
Single Sided	70.00	90.00	115.00	170.00
Double Sided	80.00	105.00	130.00	185.00

Coloured stock available at extra charge. Prices are subject to change.

TRIPLE PANEL 8 X 15 CHART



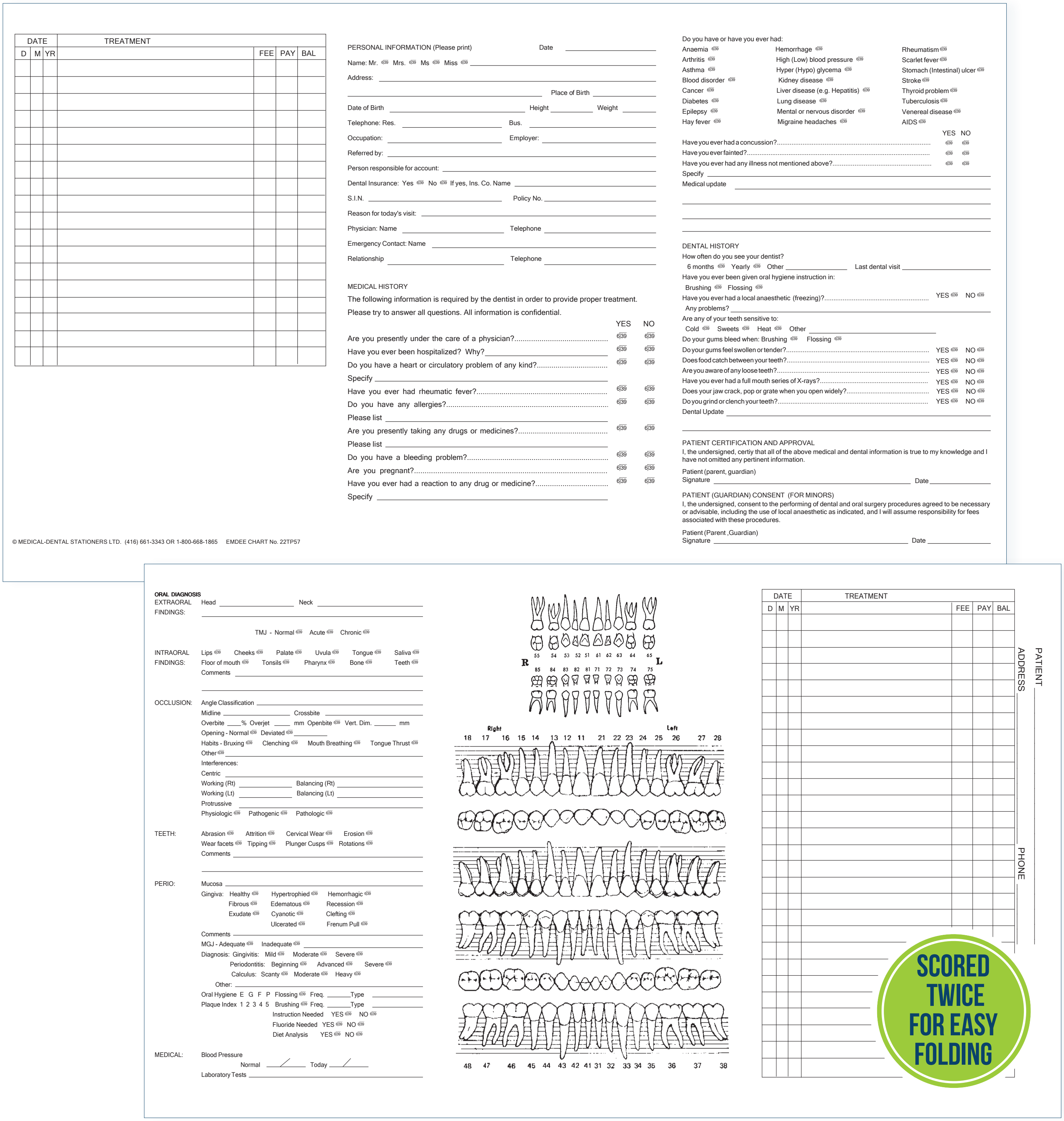
no. 22TP37 - Triple Panel Health Questionnaire

TRIPLE PANEL CHARTS

8" x 15" - Printed on 110lb white chart stock with black or green ink

Quantity	250	500	1000	2000
Double Sided - black ink	165.00	265.00	420.00	705.00
Double Sided - green ink	250.00	320.00	470.00	797.00

Prices are subject to change



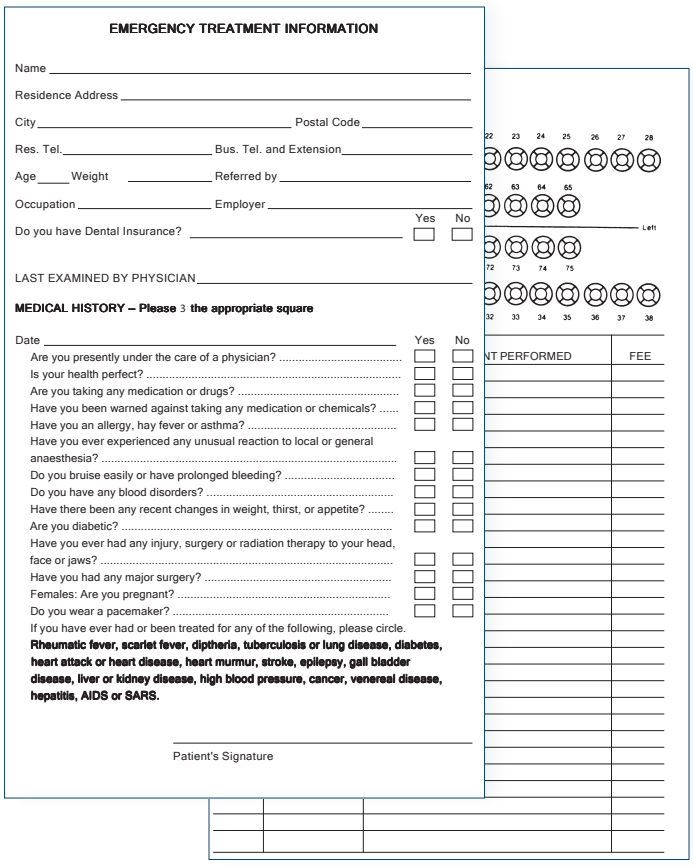
no. 22TP57 - Triple Panel Health Questionnaire

TRIPLE PANEL CHARTS

8" x 15" - Printed on 110lb white chart stock with black or green ink

Quantity	250	500	1000	2000
Double Sided - black ink	165.00	265.00	420.00	705.00
Double Sided - green ink	250.00	320.00	470.00	797.00

Prices are subject to change


EMERGENCY TREATMENT INFORMATION

Name

Residence Address

City Postal Code

Res. Tel. Bus. Tel. and Extension

Age Weight Referred by

Occupation Employer

Do you have Dental Insurance? Yes No

LAST EXAMINED BY PHYSICIAN

MEDICAL HISTORY – Please 3 the appropriate square

Date Yes No

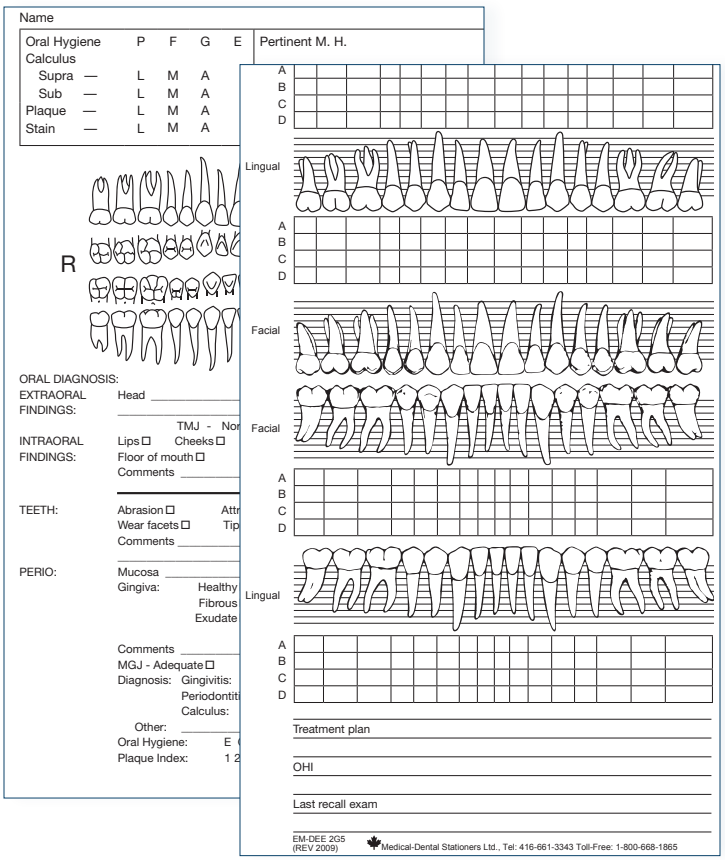
Are you presently under the care of a physician?
Is your health perfect?
Are you taking any medication or drugs?
Have you been warned against taking any medication or chemicals?
Have you an allergy, hay fever or asthma?
Have you ever experienced any unusual reaction to local or general anaesthesia?
Do you bruise easily or have prolonged bleeding?
Do you have any blood disorders?
Have there been any recent changes in weight, thirst, or appetite?
Are you diabetic?
Have you ever had any injury, surgery or radiation therapy to your head, face or jaws?
Have you had any major surgery?
Females: Are you pregnant?
Do you wear a pacemaker?

If you have ever had or been treated for any of the following, please circle.
Rheumatic fever, scarlet fever, diptheria, tuberculosis or lung disease, diabetes, heart attack or heart disease, heart murmur, stroke, epilepsy, gall bladder disease, liver or kidney disease, high blood pressure, cancer, venereal disease, hepatitis, AIDS or SARS.

Patient's Signature

NT PERFORMED FEE

no.12A41 - Emergency Treatment Information Chart


Name

Oral Hygiene P F G E
Calculus
Supra — L M A
Sub — L M A
Plaque — L M A
Stain — L M A

Pertinent M. H.

R

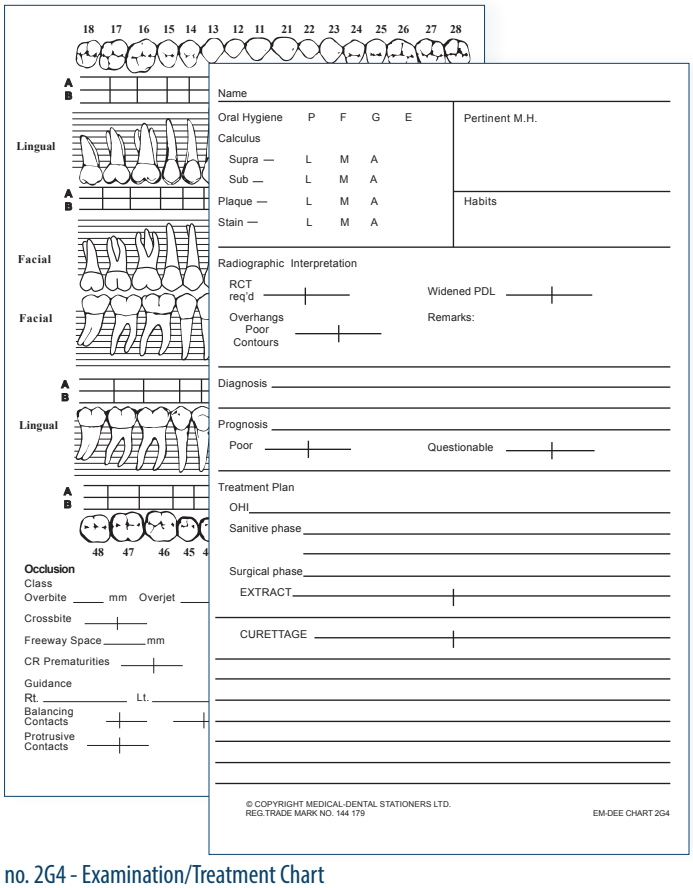
ORAL DIAGNOSIS:
EXTRAORAL FINDINGS: Head
TMJ - Nor
INTRAORAL FINDINGS: Lips ☐ Cheeks ☐
Floor of mouth ☐
Comments
TEETH: Abrasion ☐ Attr
Wear facets ☐ Tip
Comments
PERIO: Mucosa
Gingiva: Healthy
Fibrous
Exudate
Comments
MGJ - Adequate ☐
Diagnosis: Gingivitis:
Periodontiti
Calculus:
Other:
Oral Hygiene: E
Plaque Index: 1 2

A B C D Lingual
A B C D
Facial
Facial
A B C D
A B C D Lingual
A B C D

Treatment plan
OHI
Last recall exam

EM-DEE 2G5 (REV 2009) Medical-Dental Stationers Ltd., Tel: 416-661-3343 Toll-Free: 1-800-668-1865

no. 2G5 - Examination/Treatment Chart


18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28

A B Lingual A B Facial Facial A B Lingual A B

48 47 46 45

Occlusion
Class
Overbite mm Overjet
Crossbite
Freeway Space mm
CR Prematurities
Guidance
Rt. Lt.
Balancing Contacts
Protrusive Contacts

Name

Oral Hygiene P F G E
Calculus
Supra — L M A
Sub — L M A
Plaque — L M A
Stain — L M A

Pertinent M.H.

Habits

Radiographic Interpretation
RCT req'd
Widened PDL
Overhangs Poor Contours
Remarks:

Diagnosis
Prognosis
Poor
Questionable

Treatment Plan
OHI
Sanitive phase
Surgical phase
EXTRACT
CURETTAGE

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REG.TRADE MARK NO. 144 179

EM-DEE CHART 2G4

no. 2G4 - Examination/Treatment Chart

yellow	ivory	salmon
green	blue	cherry

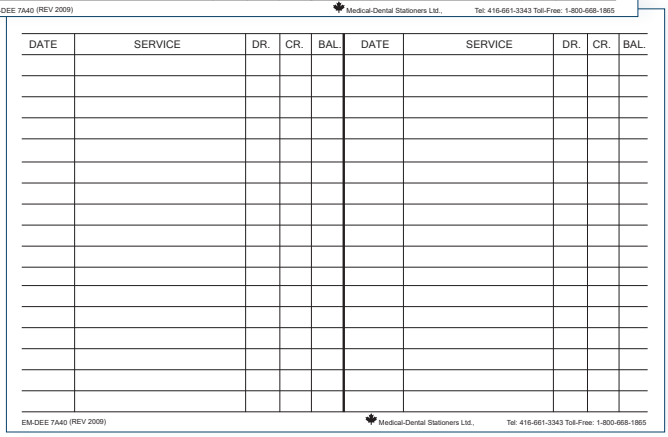
MAKE YOUR CHARTS STAND OUT BY PRINTING THEM ON COLOURED STOCK

CHARTS • 5 X 8

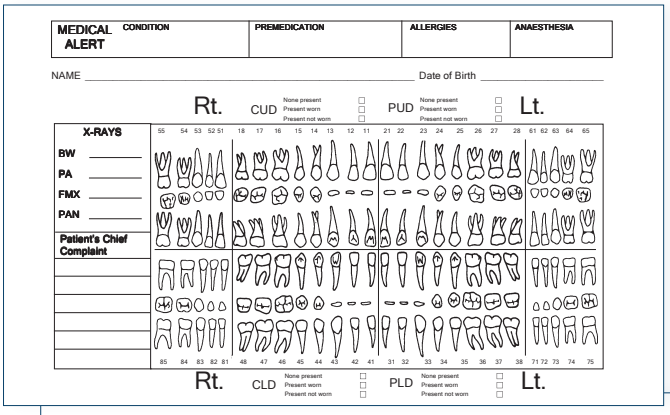
Printed double sided on 110lb white chart stock with black ink

Quantity	250	500	1000	2000
5" x 8" Cards	77.00	105.00	140.00	225.00

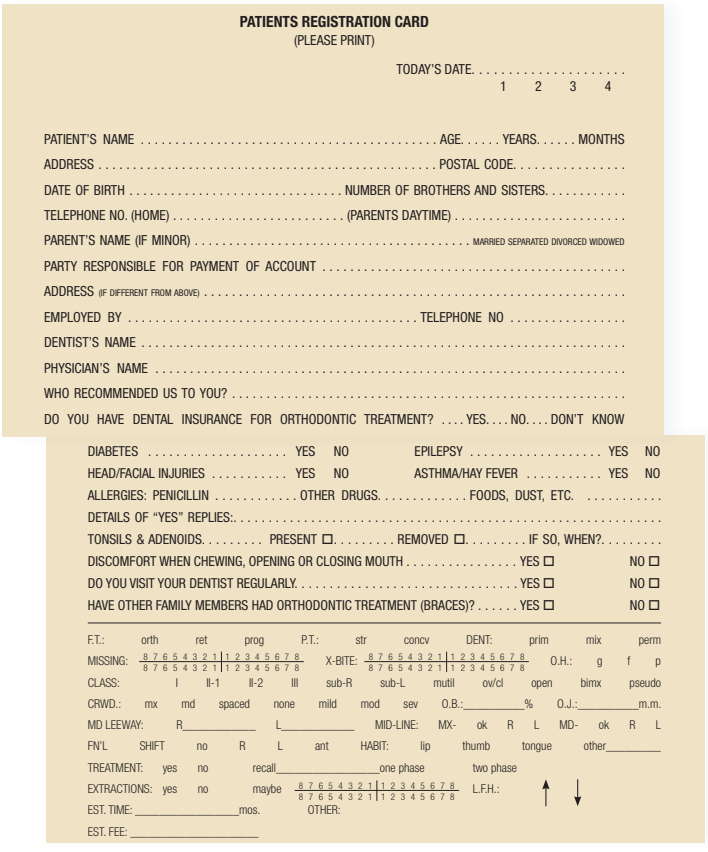
Coloured stock available at extra charge. Prices are subject to change.



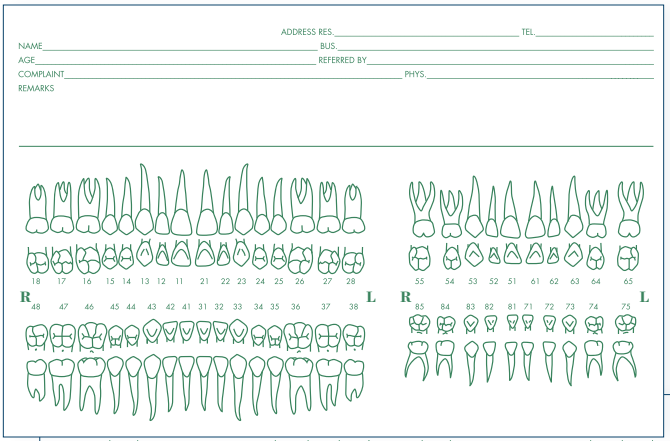
no.7A40 - Service Chart, double sided

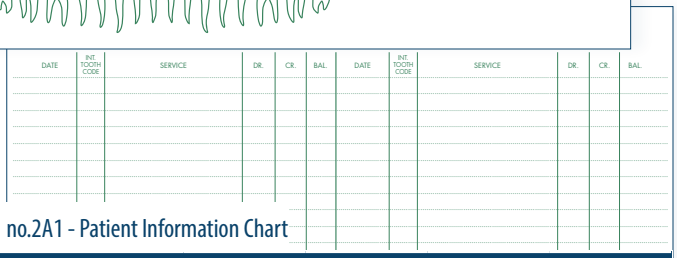


no.12A67 - Exam/Treatment Chart



no.17B15 - Patient Registration Chart on ivory stock





no.2A1 - Patient Information Chart

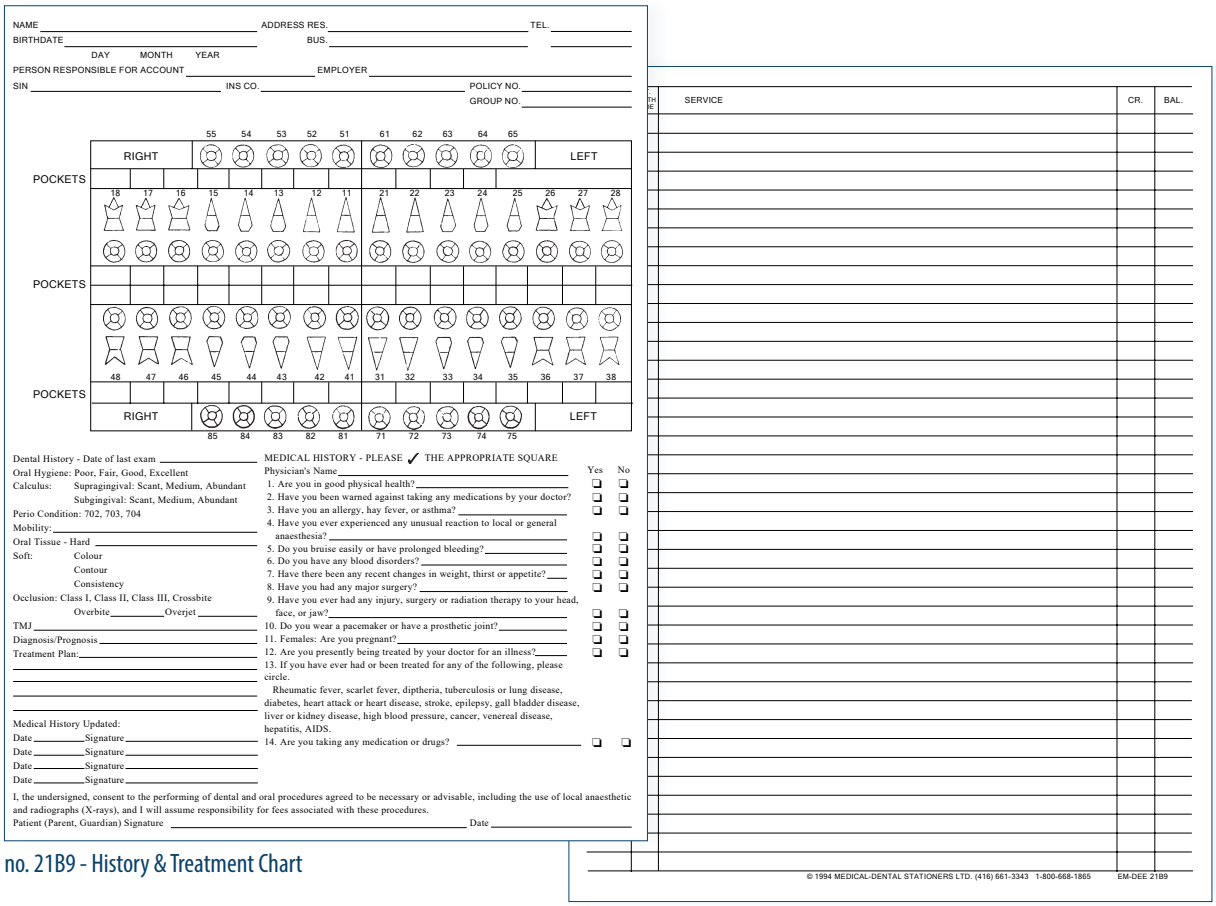
CHARTS • 5 X 8

Printed double sided on 110lb white chart stock with black ink

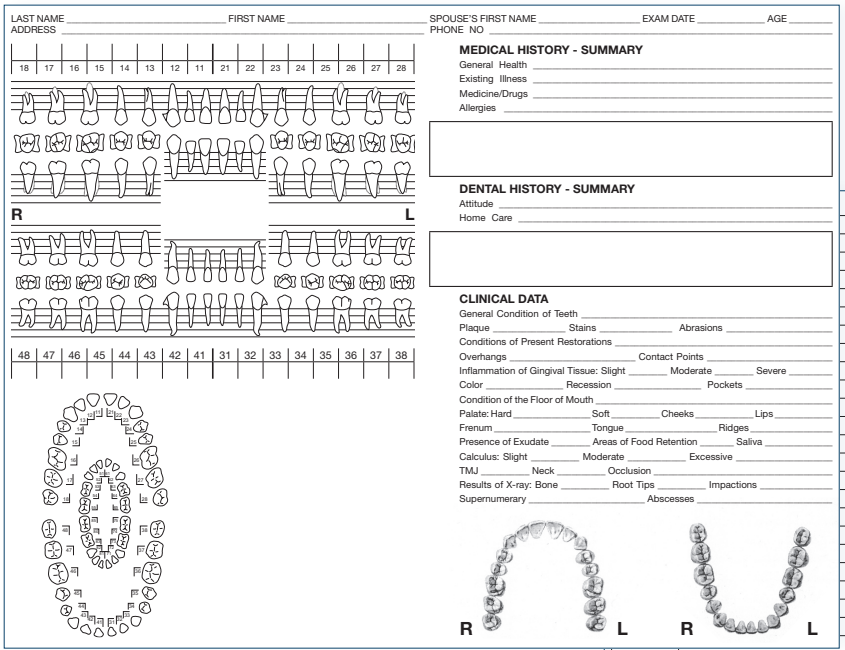
Quantity	250	500	1000	2000
5" x 8" Cards	77.00	105.00	140.00	225.00
no. 17B15 - ivory stock	92.00	115.00	160.00	240.00

Coloured stock available at extra charge. Prices are subject to change.

CHARTS • 8.5 X 11



no. 21B9 - History & Treatment Chart



no. 21C1R - History & Treatment Chart

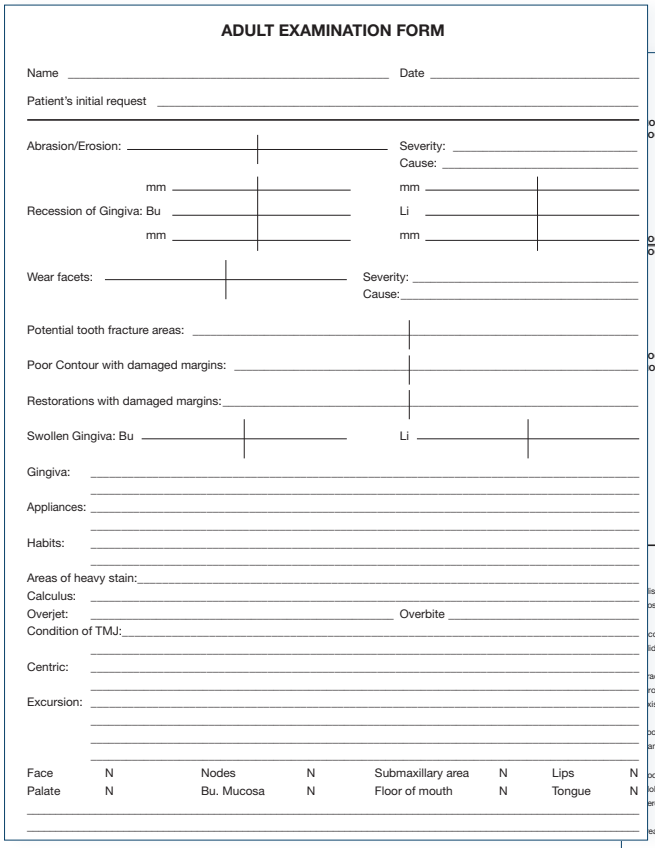
CHARTS • 8.5 X 11

Printed double sided on 110lb white chart stock with black ink

Quantity	250	500	1000	2000
8.5" x 11" Cards	125.00	180.00	275.00	435.00

Coloured stock available at extra charge. Prices are subject to change.

CHARTS • 8.5 X 11



ADULT EXAMINATION FORM

Name _____ Date _____

Patient's initial request _____

Abrasion/Erosion: _____ Severity: _____
Cause: _____

Recession of Gingiva: Bu mm _____ mm _____ Li mm _____ mm _____

Wear facets: _____ Severity: _____
Cause: _____

Potential tooth fracture areas: _____

Poor Contour with damaged margins: _____

Restorations with damaged margins: _____

Swollen Gingiva: Bu _____ Li _____

Gingiva: _____

Appliances: _____

Habits: _____

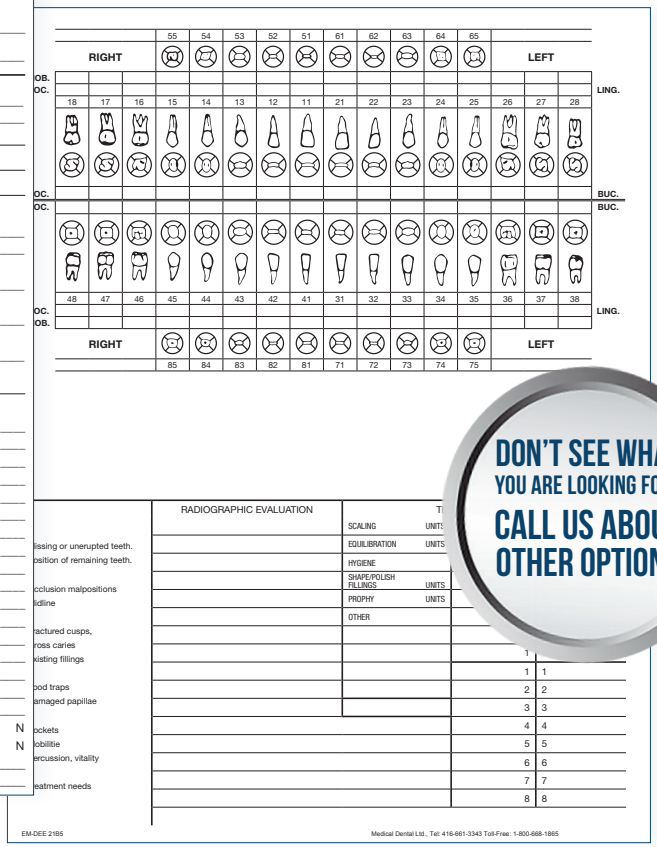
Areas of heavy stain: _____
Calculus: _____
Overjet: _____ Overbite _____
Condition of TMJ: _____

Centric: _____

Excursion: _____

Face	N	Nodes	N	Submaxillary area	N	Lips	N
Palate	N	Bu. Mucosa	N	Floor of mouth	N	Tongue	N

no. 21B5 - Adult Examination Form



RIGHT 55 54 53 52 51 61 62 63 64 65 LEFT
18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28
48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38
RIGHT 85 84 83 82 81 71 72 73 74 75 LEFT
OB. OC. LING. BUC.

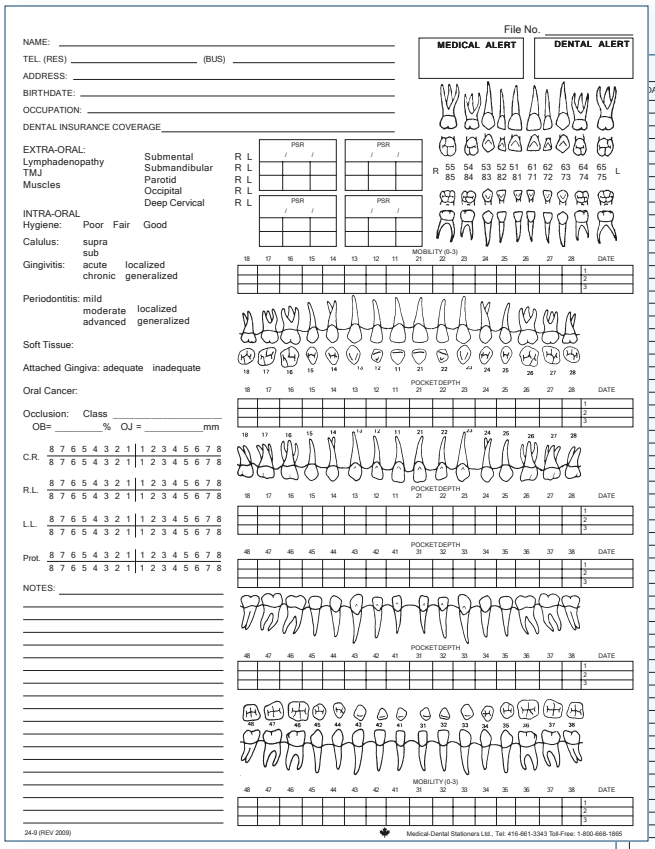
RADIOGRAPHIC EVALUATION

missing or unerupted teeth.
position of remaining teeth.
occlusion malpositions
midline
fractured cusps,
cross caries
existing fillings
food traps
damaged papillae
pockets
mobilitie
percussion, vitality
treatment needs

	UNITS
SCALING	
EQUILIBRATION	
HYGIENE	
SHAPE/POLISH FILLINGS	
PROPHY	
OTHER	

1 1
2 2
3 3
4 4
5 5
6 6
7 7
8 8

EM-DEE 21B5 Medical Dental Ltd., Tel: 416-661-3343 Toll-Free: 1-800-668-1865



NAME: _____ File No. _____
TEL. (RES) _____ (BUS) _____
ADDRESS: _____
BIRTHDATE: _____
OCCUPATION: _____
DENTAL INSURANCE COVERAGE _____

MEDICAL ALERT DENTAL ALERT

EXTRA-ORAL:
Lymphadenopathy
TMJ
Muscles
Submental
Submandibular R L
Parotid R L
Occipital R L
Deep Cervical R L

INTRA-ORAL
Hygiene: Poor Fair Good
Calulus: supra sub
Gingivitis: acute chronic localized generalized
Periodontitis: mild moderate advanced localized generalized
Soft Tissue:
Attached Gingiva: adequate inadequate
Oral Cancer:
Occlusion: Class _____
OB= _____% OJ = _____mm

C.R. 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
R.L. 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
L.L. 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
Prot. 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

NOTES: _____

PSR / /

R 55 54 53 52 51 61 62 63 64 65 L
85 84 83 82 81 71 72 73 74 75

18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28 DATE
MOBILITY (0-3)
POCKETDEPTH
48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38 DATE

24-9 (REV 2009) Medical-Dental Stationers Ltd., Tel: 416-661-3343 Toll-Free: 1-800-668-1865

no. 21B17 - Examination Form

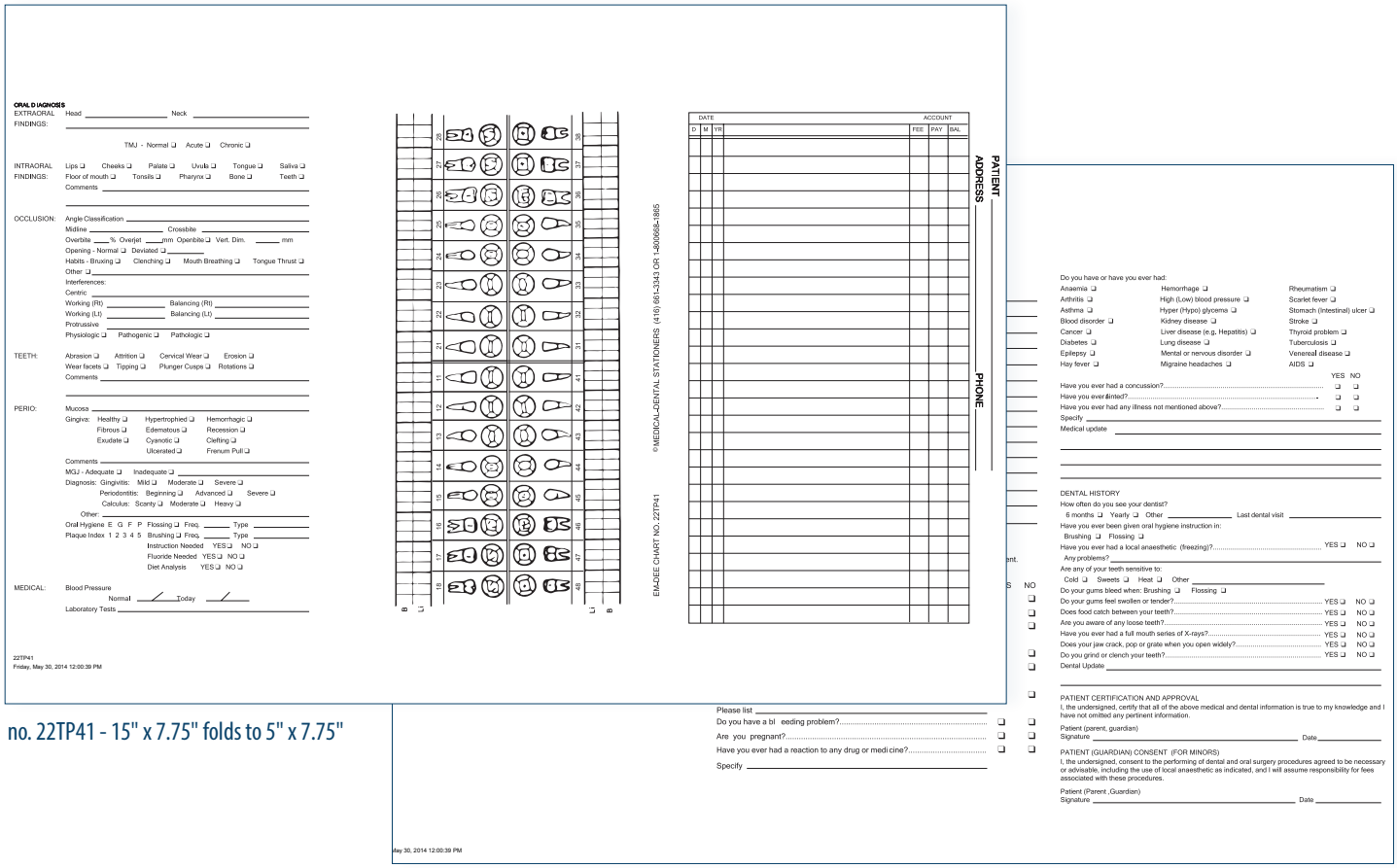
DATE	TREATMENT	FEE	CR.	BAL

CHARTS • 8.5 X 11

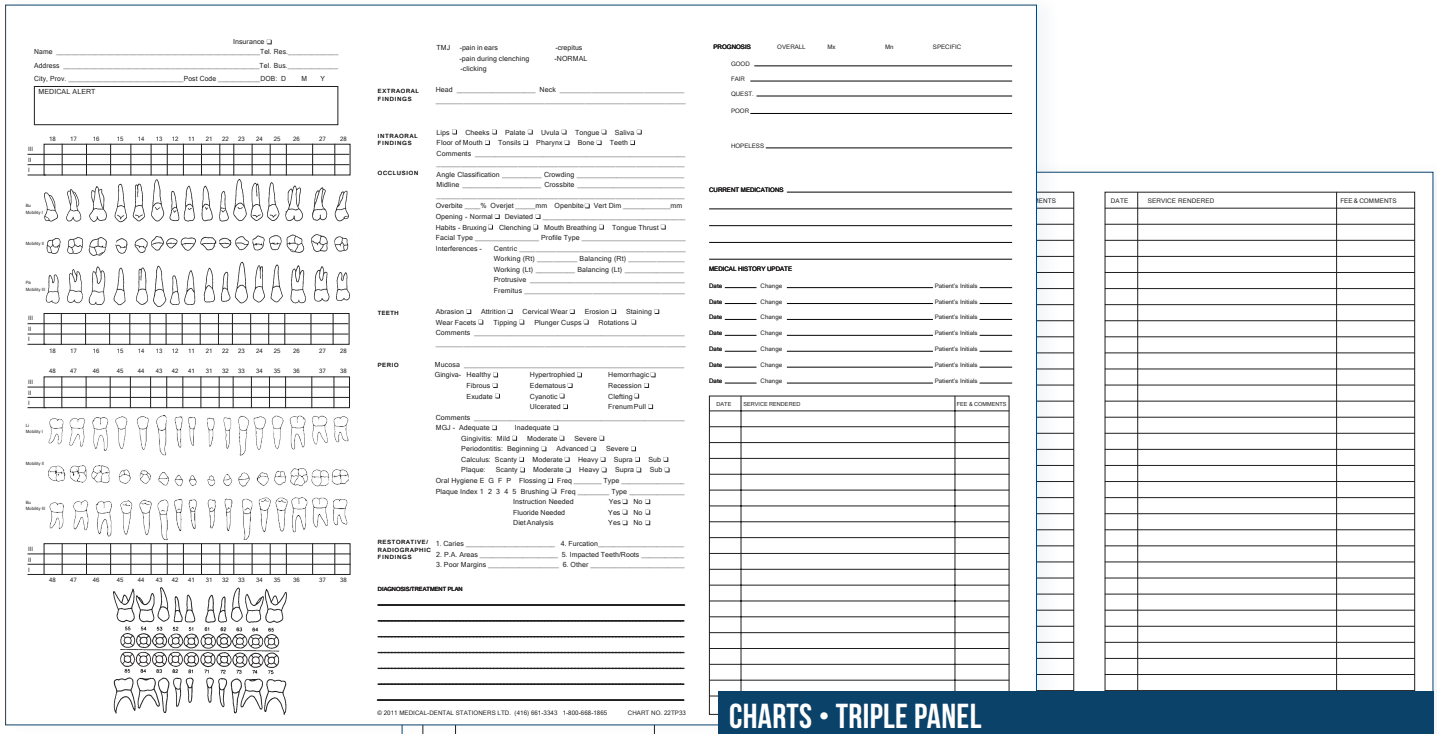
Printed double sided on 110lb white chart stock with black ink

Quantity	250	500	1000	2000
8.5" x 11" Cards	125.00	180.00	275.00	435.00

Coloured stock available at extra charge. Prices are subject to change.



no. 22TP41 - 15" x 7.75" folds to 5" x 7.75"



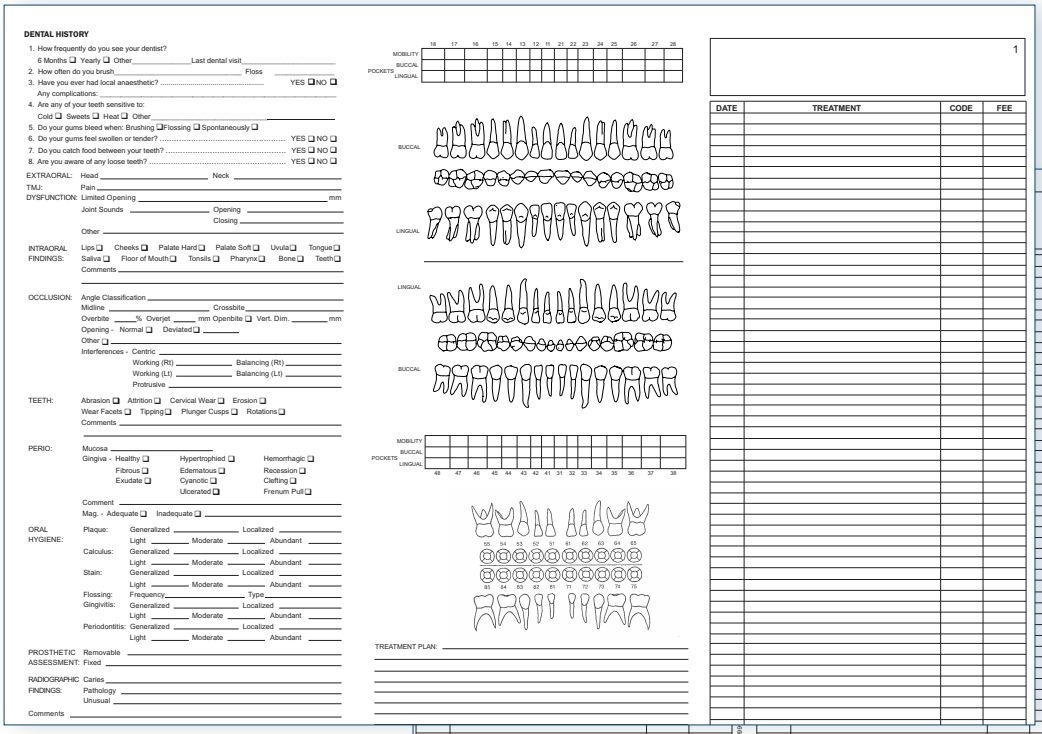
no. 22TP33 - 15" x 7.75" folds to 5" x 7.75"

CHARTS • TRIPLE PANEL

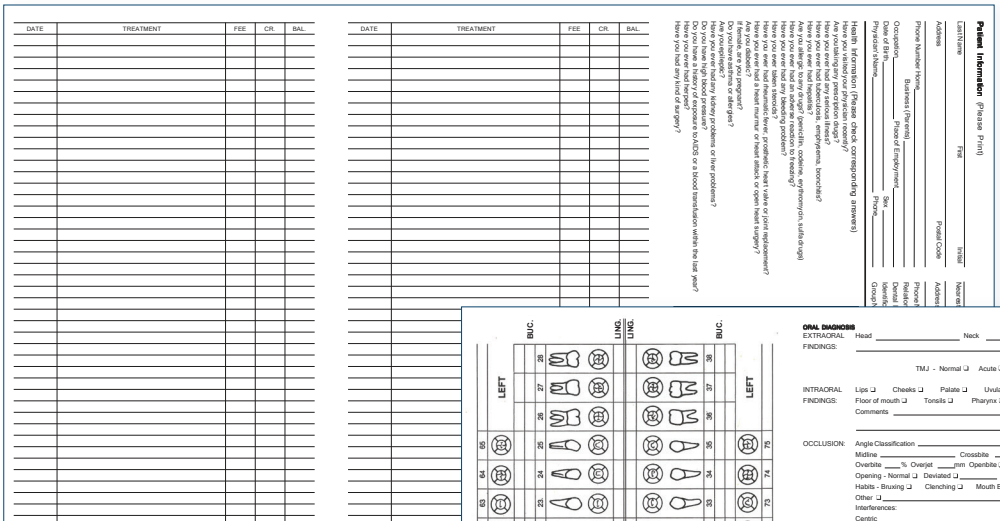
Printed on 110lb white chart stock, black ink

	250	500	1000	2000
Double Sided	165.00	265.00	420.00	705.00

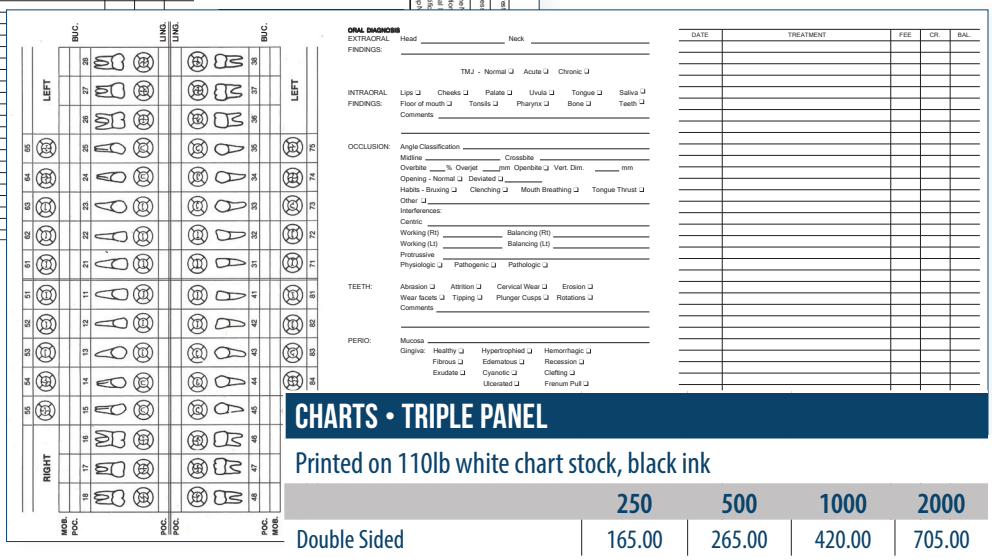
Coloured stock available at extra charge. Prices are subject to change.



no. 22TP45 - 11" x 15.75" folds to 5.5" x 11"



no. 22TP18 - 15.75" x 8.5" folds to 5.25" x 8.5"



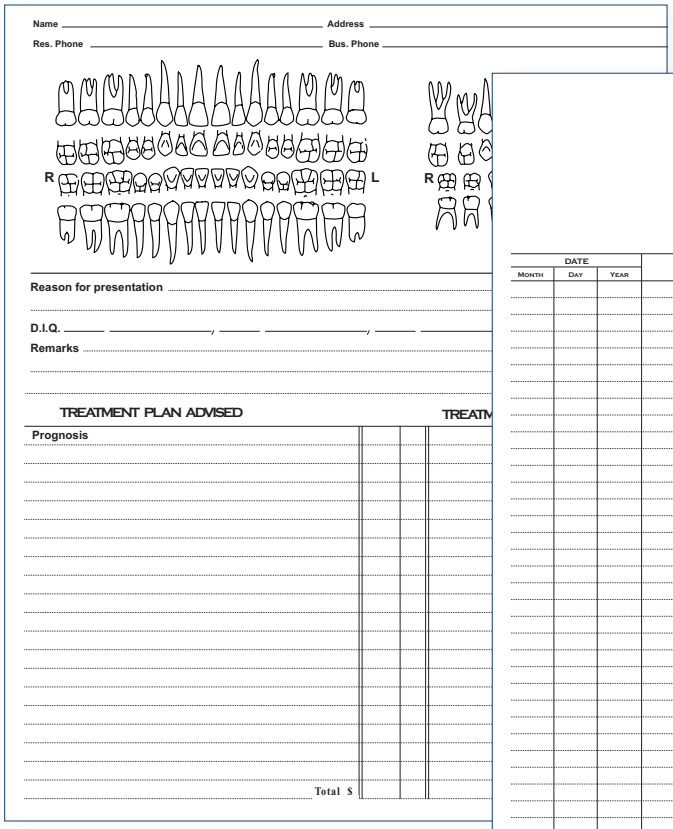
CHARTS • TRIPLE PANEL

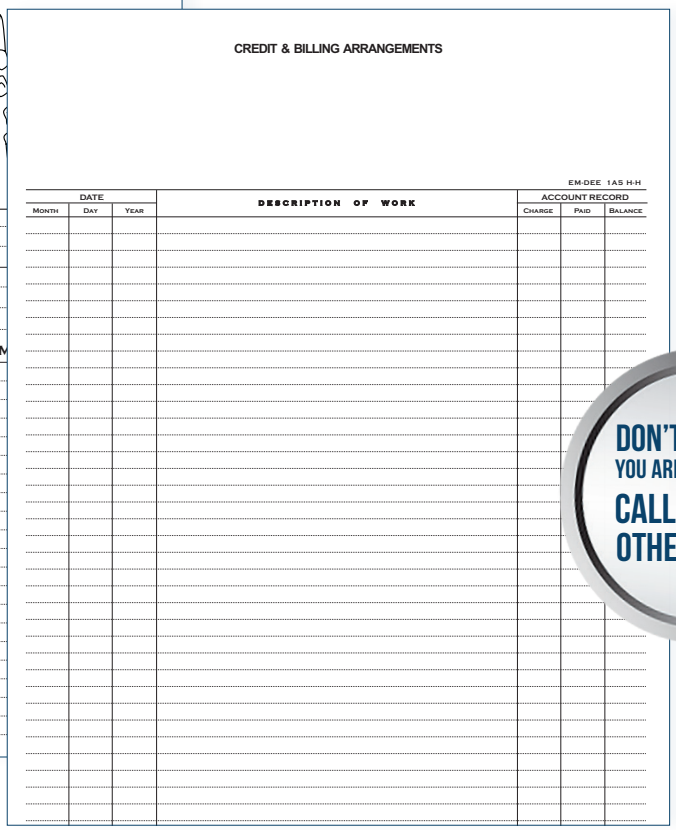
Printed on 110lb white chart stock, black ink

	250	500	1000	2000
Double Sided	165.00	265.00	420.00	705.00

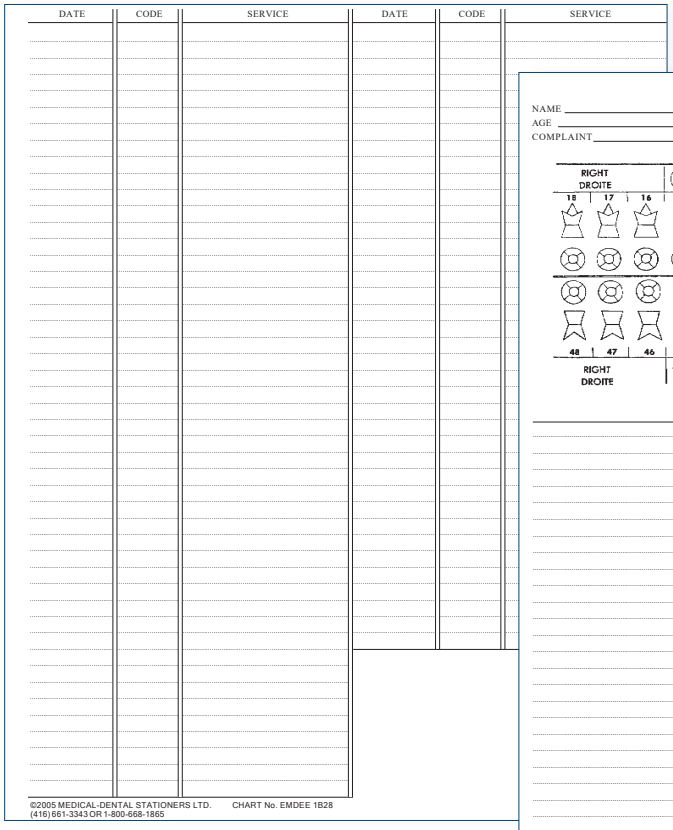
Coloured stock available at extra charge. Prices are subject to change.

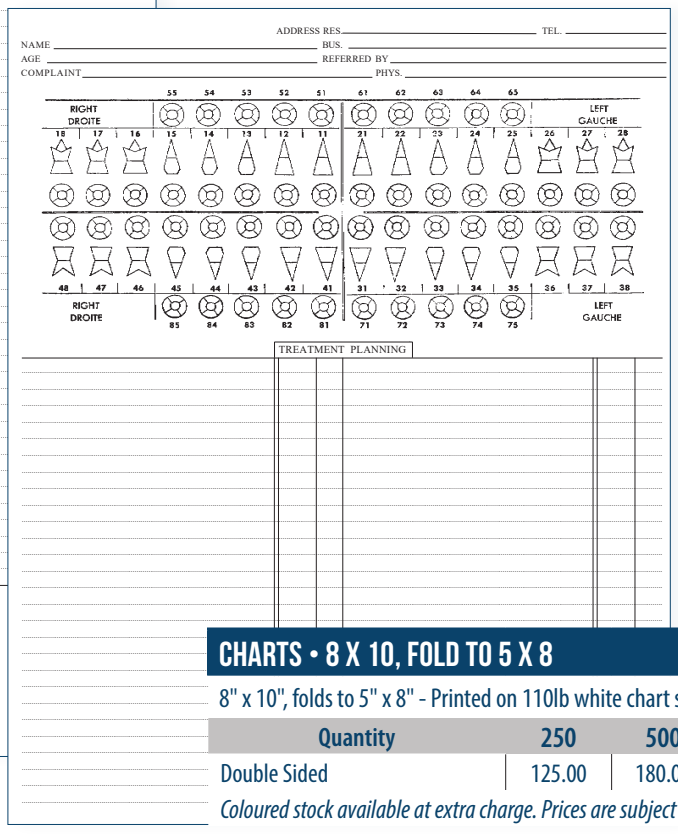
CHARTS • 8 x 10, FOLD to 5 x 8


Name Address
Res. Phone Bus. Phone
R L
Reason for presentation
D.I.Q.
Remarks
TREATMENT PLAN ADVISED
Prognosis
Total $


CREDIT & BILLING ARRANGEMENTS
EM-DEE 1A5 H-H
DATE Month Day Year
DESCRIPTION OF WORK
ACCOUNT RECORD Charge Paid Balance

no.1A5HH - Treatment Plan Chart


DATE CODE SERVICE DATE CODE SERVICE
©2005 MEDICAL-DENTAL STATIONERS LTD. CHART No. EMDEE 1B28
(416) 661-3343 OR 1-800-668-1865


ADDRESS RES TEL.
NAME BUS.
AGE REFERRED BY
COMPLAINT PHYS.
RIGHT DROITE
LEFT GAUCHE
TREATMENT PLANNING

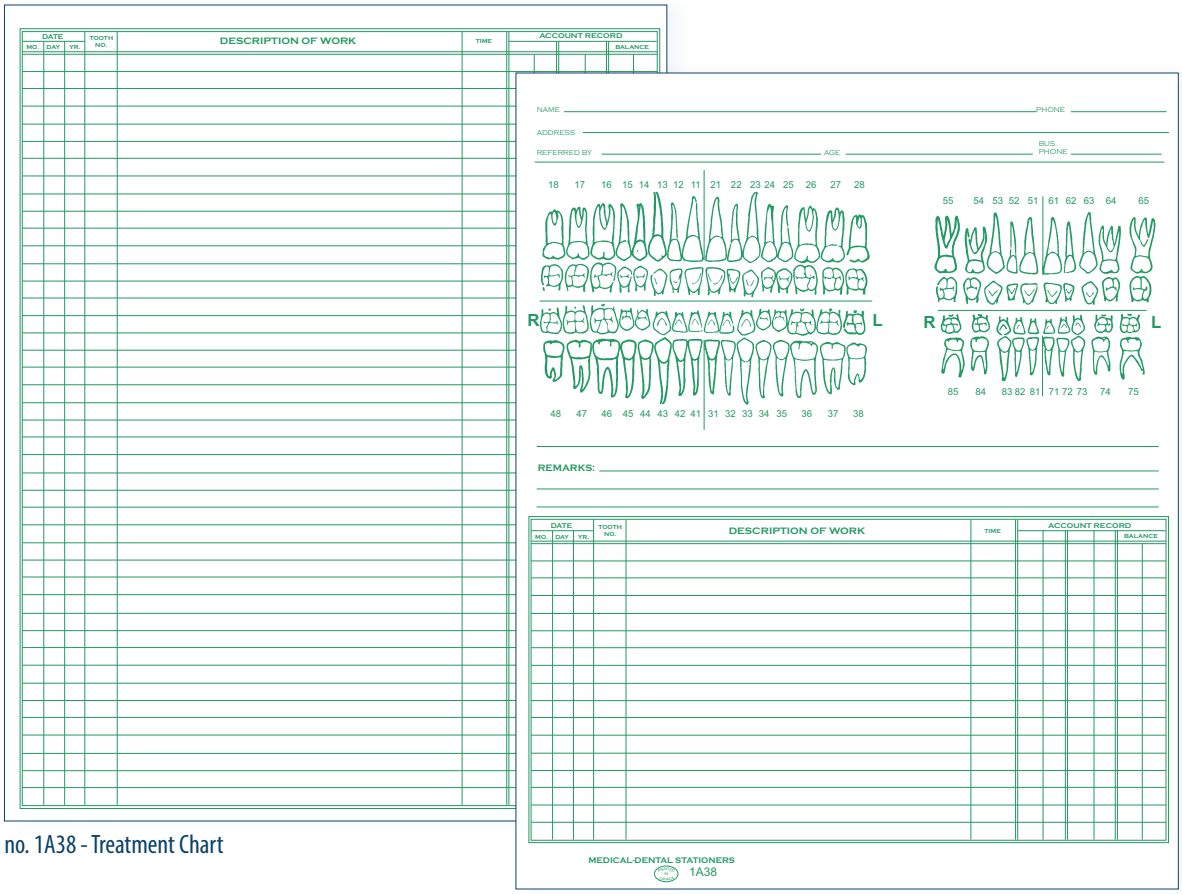
no. 1B28 - Treatment Chart

CHARTS • 8 X 10, FOLD TO 5 X 8

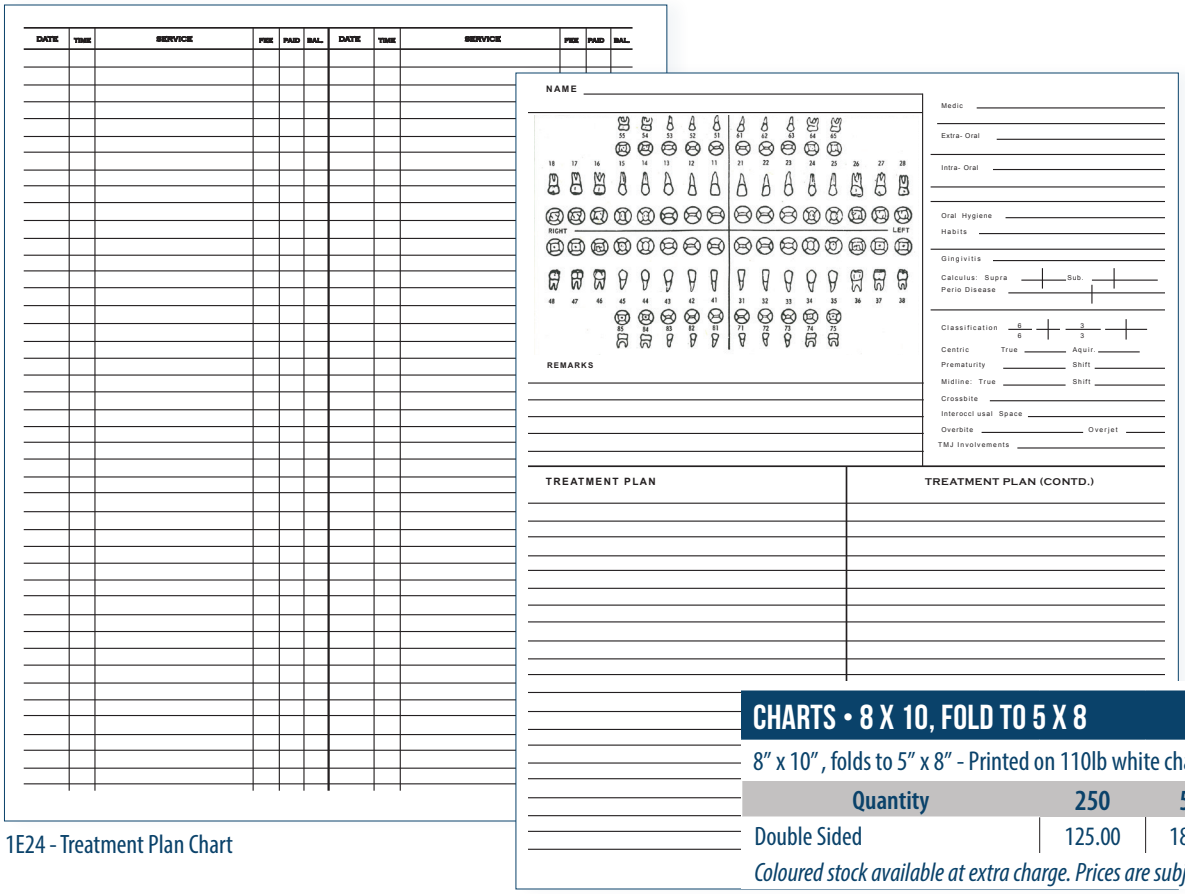
8" x 10", folds to 5" x 8" - Printed on 110lb white chart stock with black ink

Quantity	250	500	1000	2000
Double Sided	125.00	180.00	275.00	435.00

Coloured stock available at extra charge. Prices are subject to change.



no. 1A38 - Treatment Chart



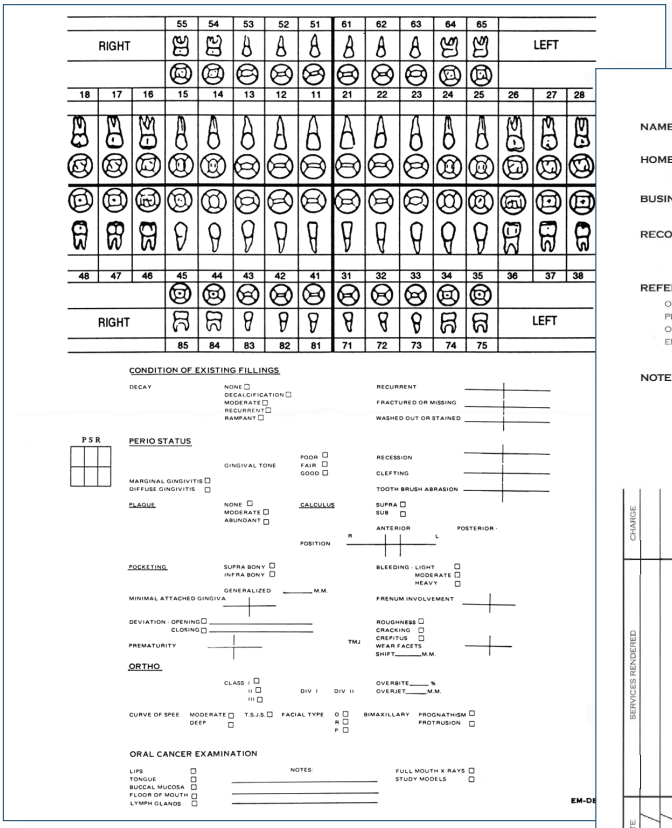
1E24 - Treatment Plan Chart

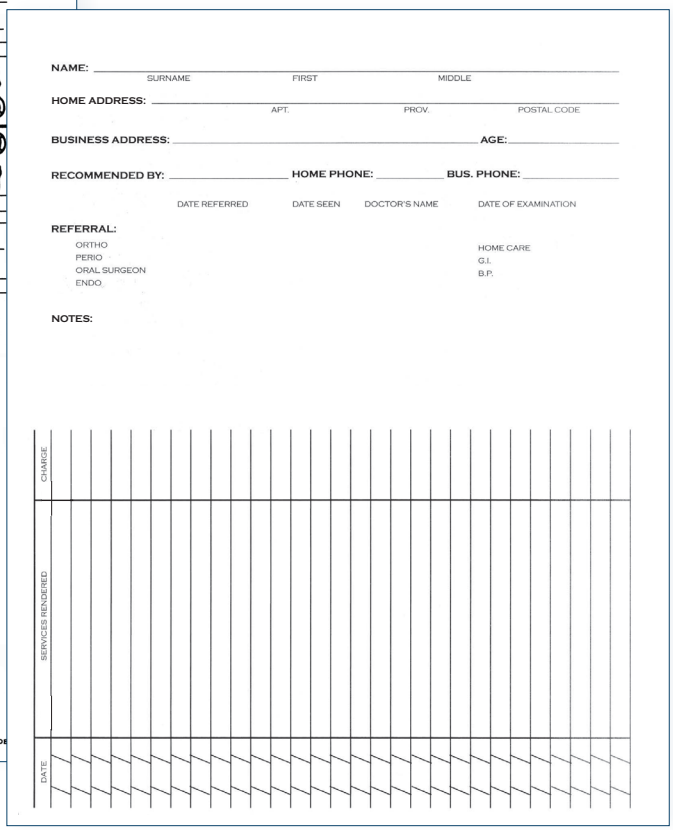
CHARTS • 8 X 10, FOLD TO 5 X 8

8" x 10", folds to 5" x 8" - Printed on 110lb white chart stock with black ink

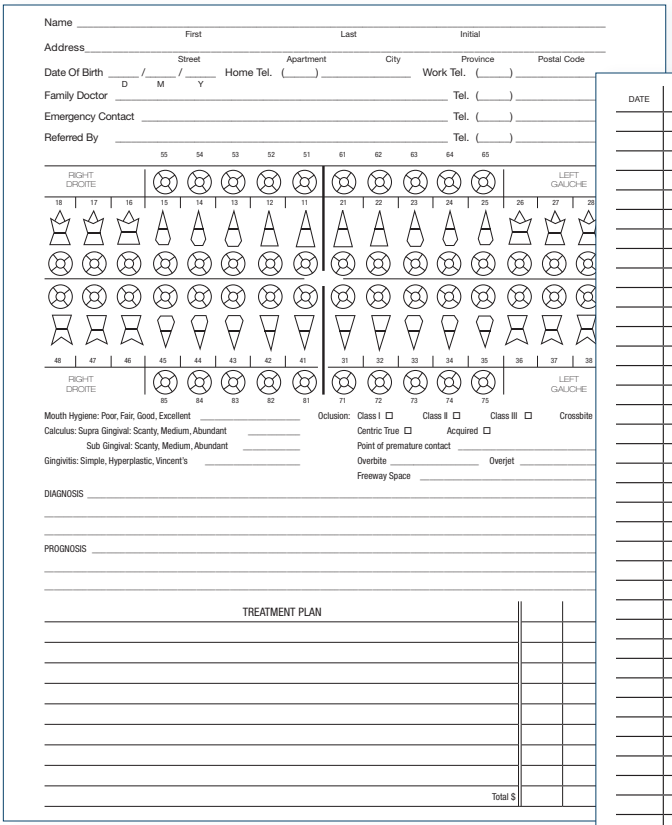
Quantity	250	500	1000	2000
Double Sided	125.00	180.00	275.00	435.00

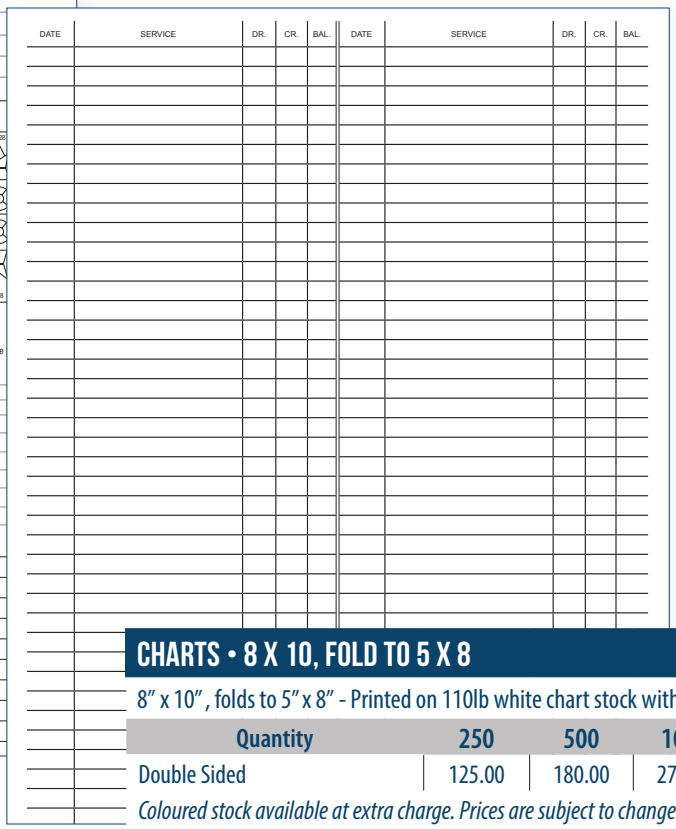
Coloured stock available at extra charge. Prices are subject to change.





no.1B12 - Examination Chart





no.1B1 - Exam and Treatment Chart

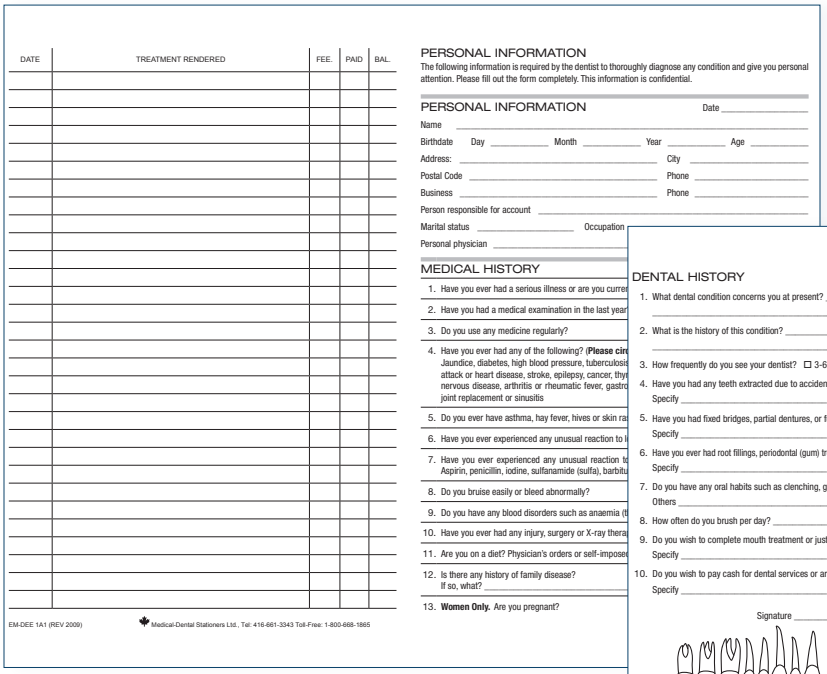
CHARTS • 8 X 10, FOLD TO 5 X 8

8" x 10", folds to 5" x 8" - Printed on 110lb white chart stock with black ink

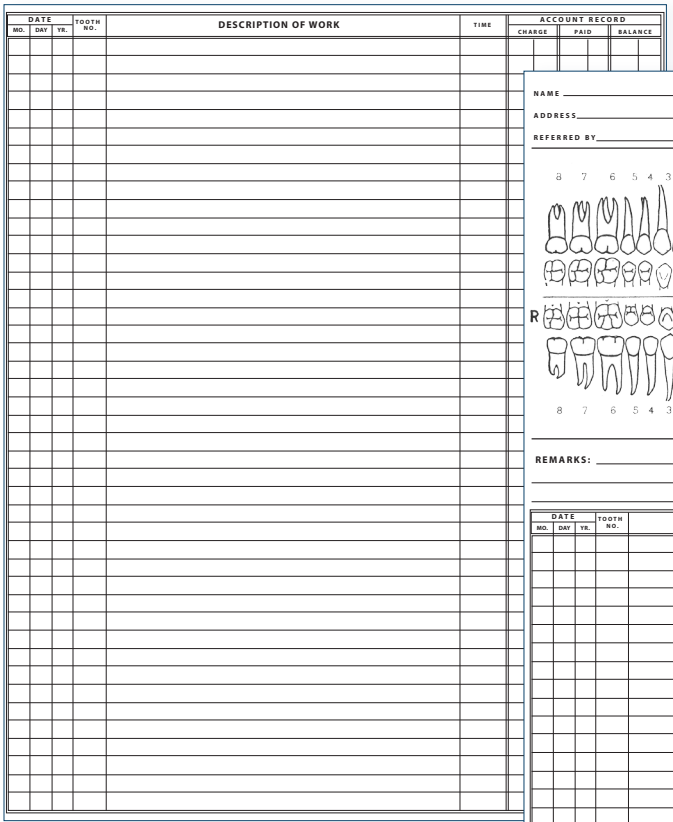
Quantity	250	500	1000	2000
Double Sided	125.00	180.00	275.00	435.00

Coloured stock available at extra charge. Prices are subject to change.

CHARTS • 8 x10, FOLD to 5 x 8



no. 1A1 - History and Exam Chart, 10" x 8"



no. 1A32W - Treatment Chart 8" x 10"

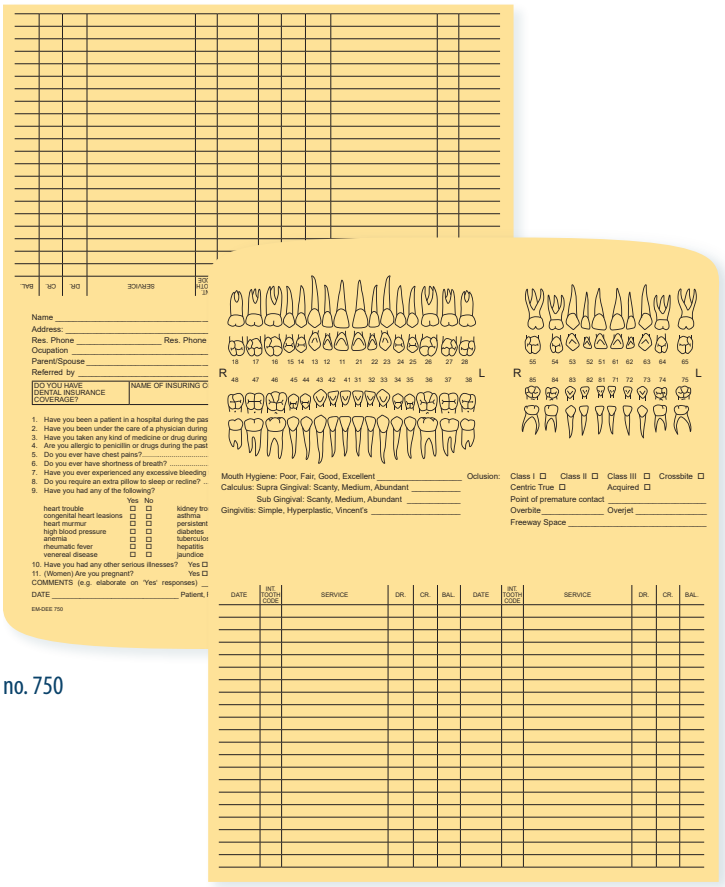
CHARTS • 8 X 10, FOLD TO 5 X 8

8" x 10" folds to 5" x 8" - Printed on 110lb white chart stock with black ink

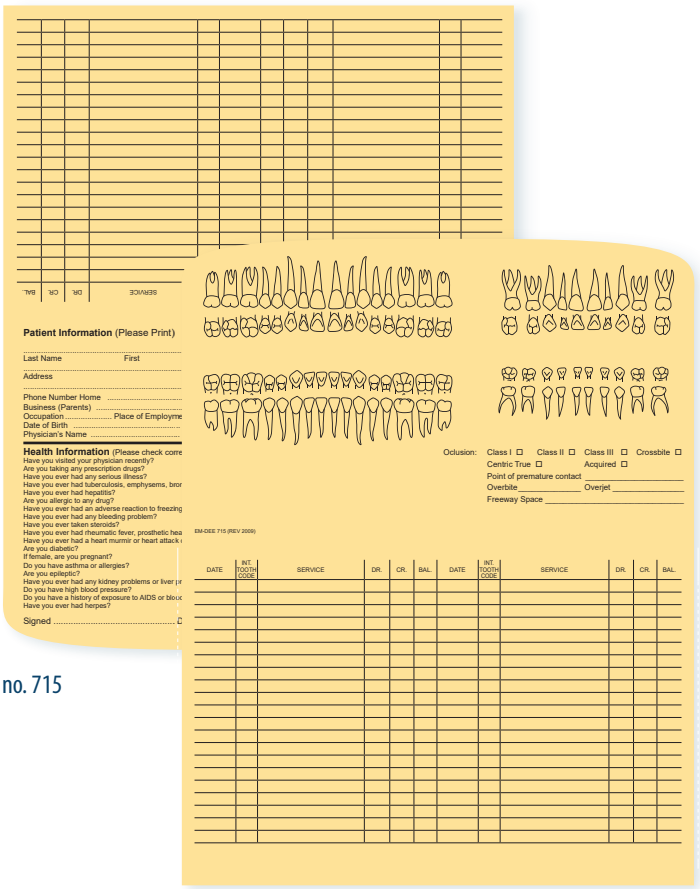
Quantity	250	500	1000	2000
Double Sided	125.00	180.00	275.00	435.00

Coloured stock available at extra charge. Prices are subject to change.

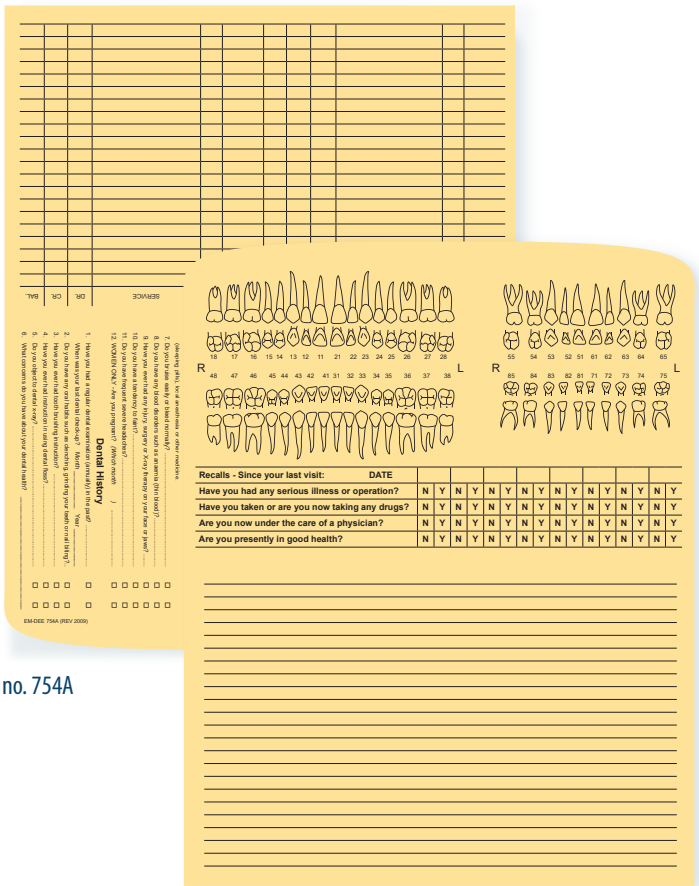
WALLET CHARTS



no. 750



no. 715



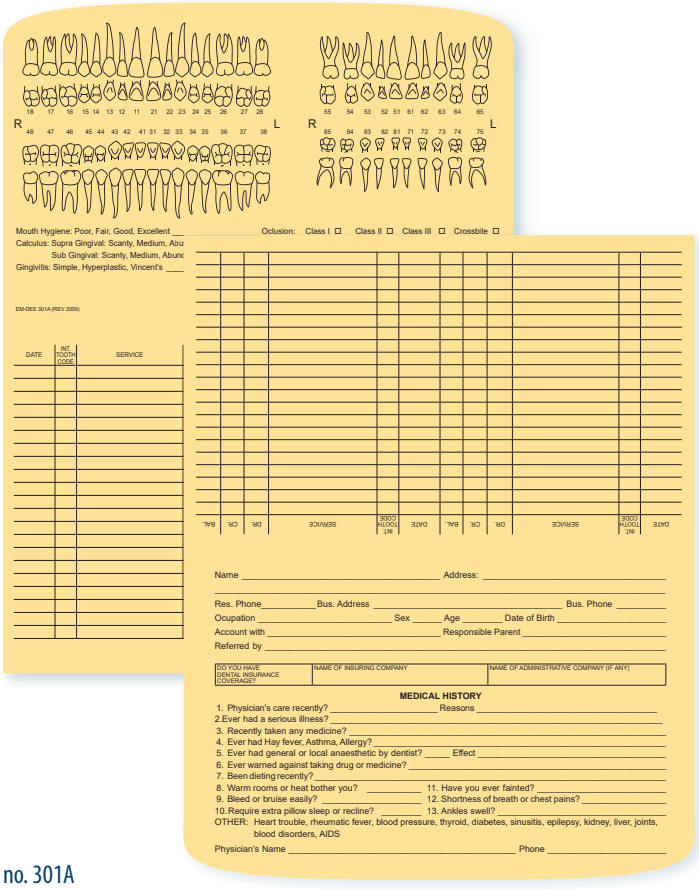
no. 754A

WALLET CHARTS

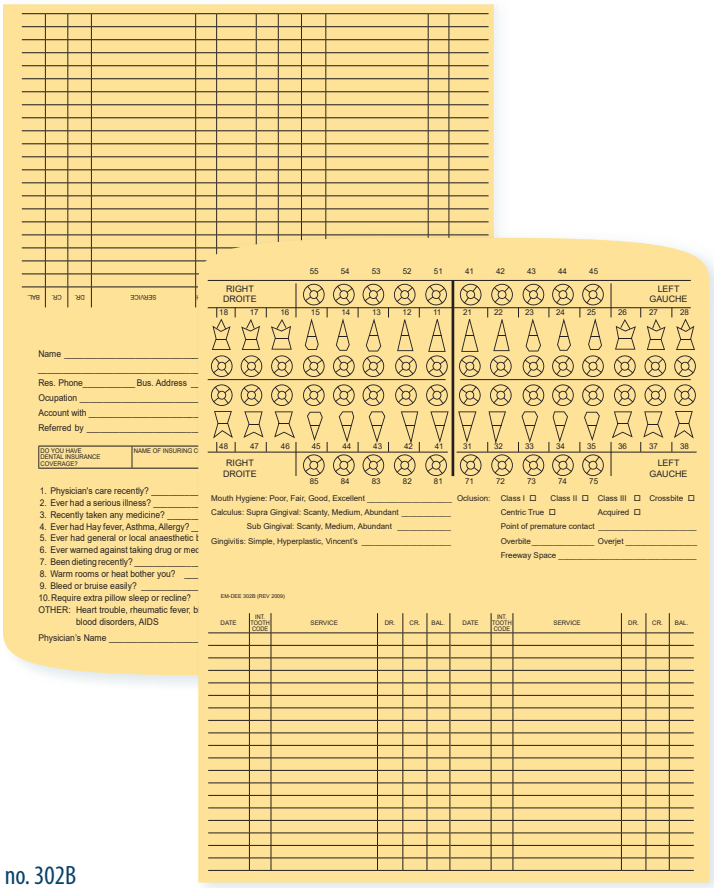
5.25" x 8.25" Pouch, Printed on wallet chart stock with black ink

	250	500	1000	2000
Double Sided	209.00	330.00	460.00	780.00

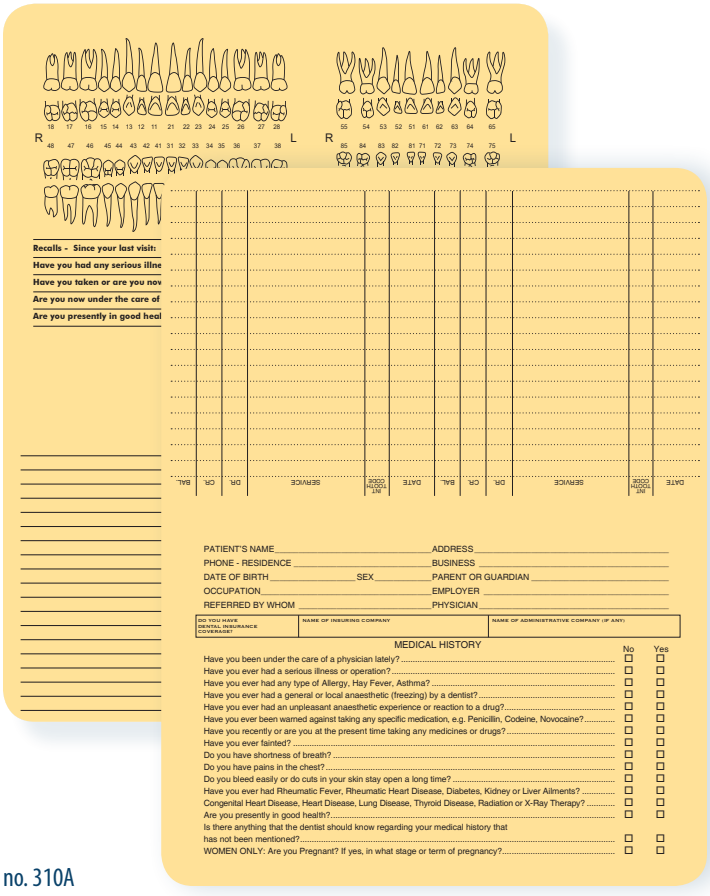
Prices are subject to change



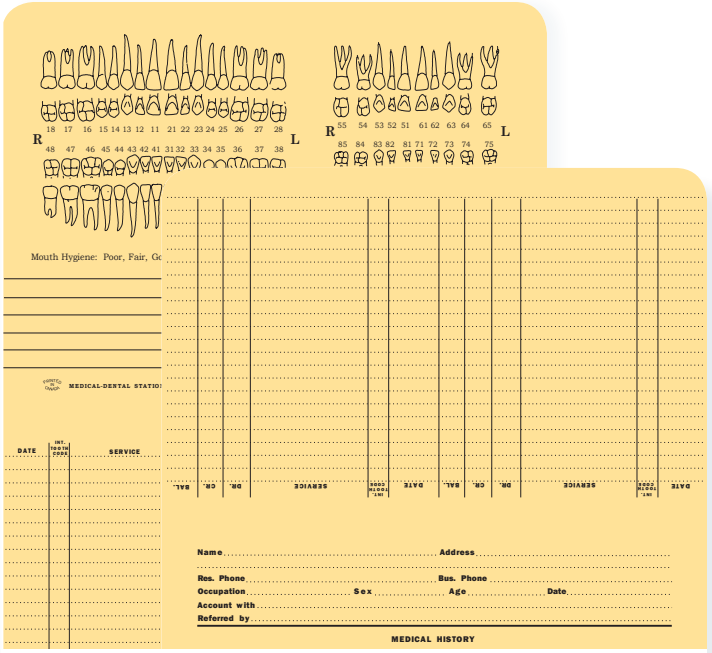
no. 301A



no. 302B



no. 310A



no. 367A

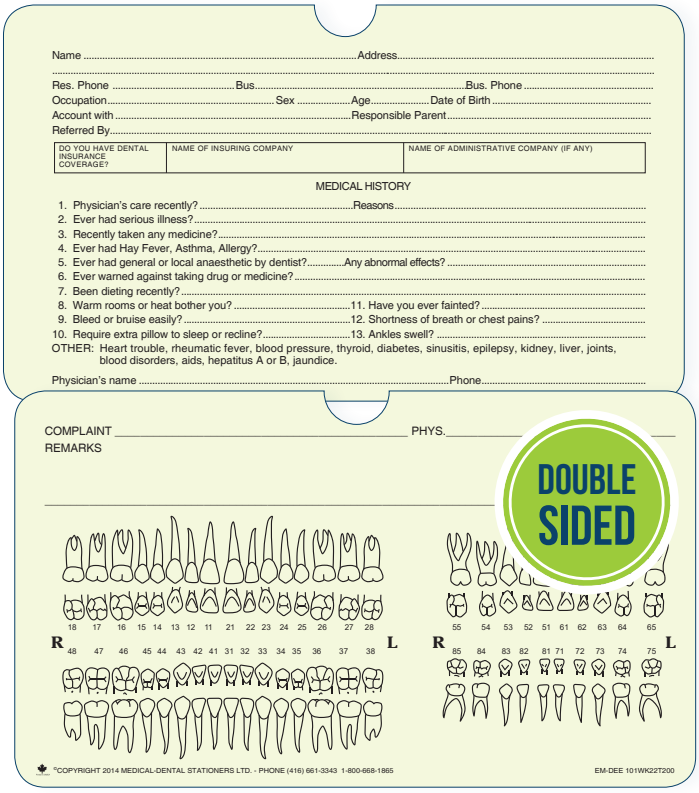
WALLET CHARTS

5.25" x 8.25" Pouch, Printed on wallet chart stock with black ink

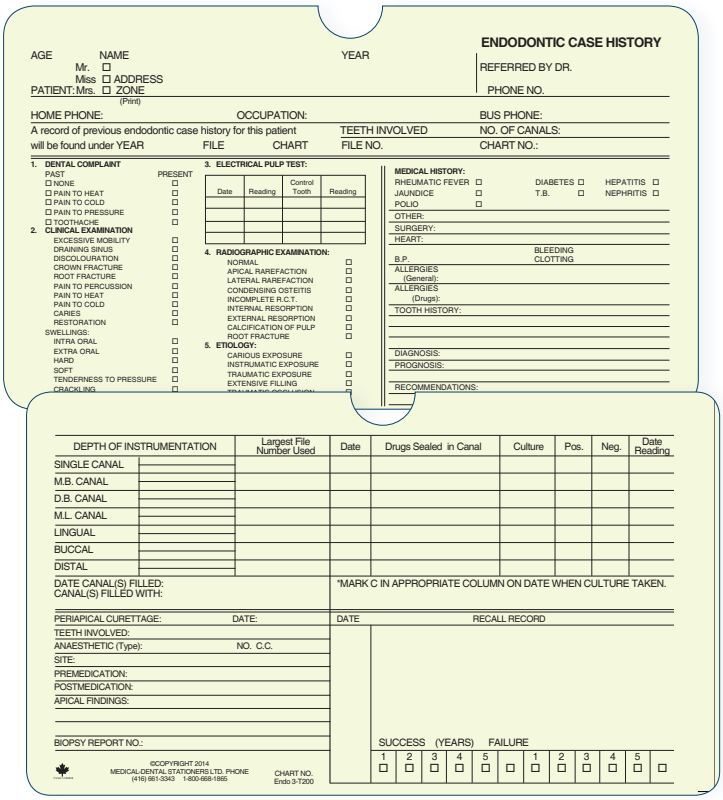
	250	500	1000	2000
Double Sided	209.00	330.00	460.00	780.00

Prices are subject to change

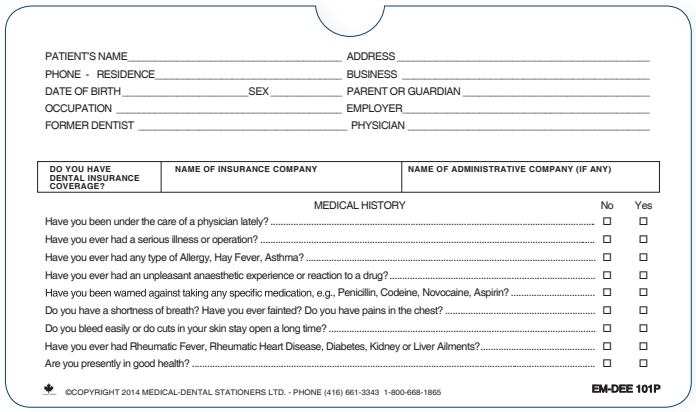
CHART ENVELOPES



no. 101WK22T200 - Filing Envelope



no. ENDO3 - Filing Envelope



no. 101P - Filing Envelope

CHART ENVELOPES - SERIES 101

101 Series - Holds Charts 5" x 8" and 8" x 10"

Product	250	500	1000	2000
101W - White	55.00	85.00	150.00	265.00
101M - Ivory	75.00	136.00	240.00	385.00
101G - Gray	75.00	136.00	240.00	385.00
200lb. Ivory	110.00	175.00	280.00	500.00

Prices are subject to change

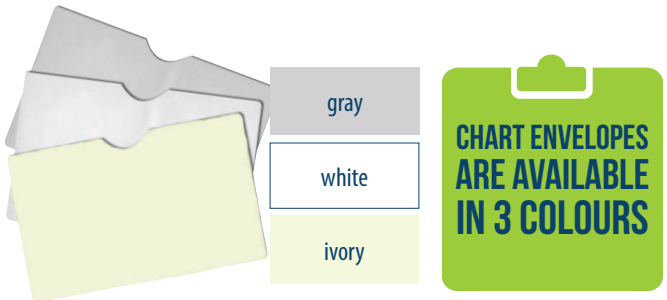
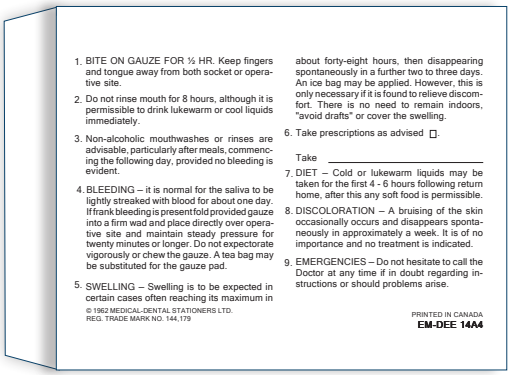


CHART ENVELOPES - SERIES 101 - PRINTED

101 Series - Holds Charts 5" x 8" and 8" x 10"

Product	250	500	1000	2000
101W - White - 1 Side	109.00	160.00	245.00	400.00
101W - White - 2 Sides	195.00	245.00	315.00	475.00
101M - Ivory - 1 Side	160.00	205.00	310.00	515.00
ENDO3 & 101M - Ivory - 2 Sides	208.00	260.00	366.00	583.00
101G - Gray - 1 Side	160.00	205.00	310.00	515.00
101G - Gray - 2 Sides	208.00	260.00	366.00	583.00
200lb. Ivory - 1 Side	170.00	230.00	340.00	605.00
200lb. Ivory - 2 Sides	230.00	305.00	425.00	645.00

Prices are subject to change



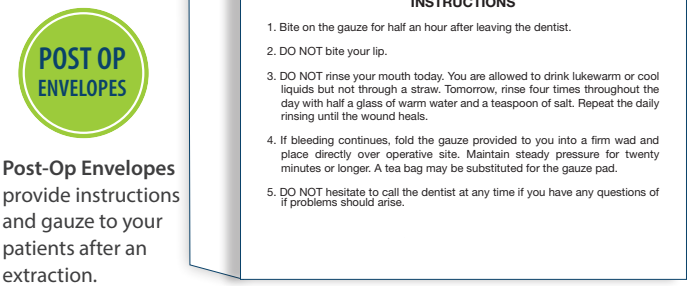
1. BITE ON GAUZE FOR ½ HR. Keep fingers and tongue away from both socket or operative site.
2. Do not rinse mouth for 8 hours, although it is permissible to drink lukewarm or cool liquids immediately.
3. Non-alcoholic mouthwashes or rinses are advisable, particularly after meals, commencing the following day, provided no bleeding is evident.
4. BLEEDING – it is normal for the saliva to be lightly streaked with blood for about one day. If frank bleeding is present fold provided gauze into a firm wad and place directly over operative site and maintain steady pressure for twenty minutes or longer. Do not expectorate vigorously or chew the gauze. A tea bag may be substituted for the gauze pad.
5. SWELLING – Swelling is to be expected in certain cases often reaching its maximum in about forty-eight hours, then disappearing spontaneously in a further two to three days. An ice bag may be applied. However, this is only necessary if it is found to relieve discomfort. There is no need to remain indoors, "avoid drafts" or cover the swelling.
6. Take prescriptions as advised ☐.

Take _____

7. DIET – Cold or lukewarm liquids may be taken for the first 4 - 6 hours following return home, after this any soft food is permissible.
8. DISCOLORATION – A bruising of the skin occasionally occurs and disappears spontaneously in approximately a week. It is of no importance and no treatment is indicated.
9. EMERGENCIES – Do not hesitate to call the Doctor at any time if in doubt regarding instructions or should problems arise.

PRINTED IN CANADA
EM-DEE 14A4

no. 14A4 - Post Op Envelope



INSTRUCTIONS

1. Bite on the gauze for half an hour after leaving the dentist.
2. DO NOT bite your lip.
3. DO NOT rinse your mouth today. You are allowed to drink lukewarm or cool liquids but not through a straw. Tomorrow, rinse four times throughout the day with half a glass of warm water and a teaspoon of salt. Repeat the daily rinsing until the wound heals.
4. If bleeding continues, fold the gauze provided to you into a firm wad and place directly over operative site. Maintain steady pressure for twenty minutes or longer. A tea bag may be substituted for the gauze pad.
5. DO NOT hesitate to call the dentist at any time if you have any questions of if problems should arise.

POST OP ENVELOPES

Post-Op Envelopes provide instructions and gauze to your patients after an extraction.

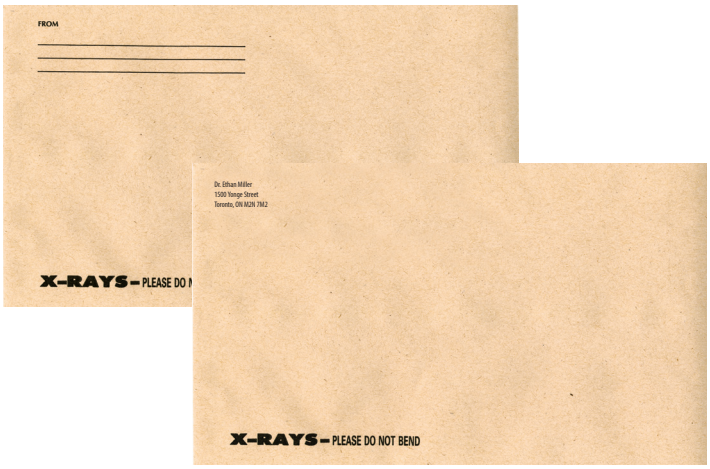
no. 14A5 - Post Op Envelope

POST-OP ENVELOPES

3.25" x 4.75"

Quantity	100	250	500	1000
14A4 , 14A5	55.00	90.00	165.00	290.00

Prices are subject to change

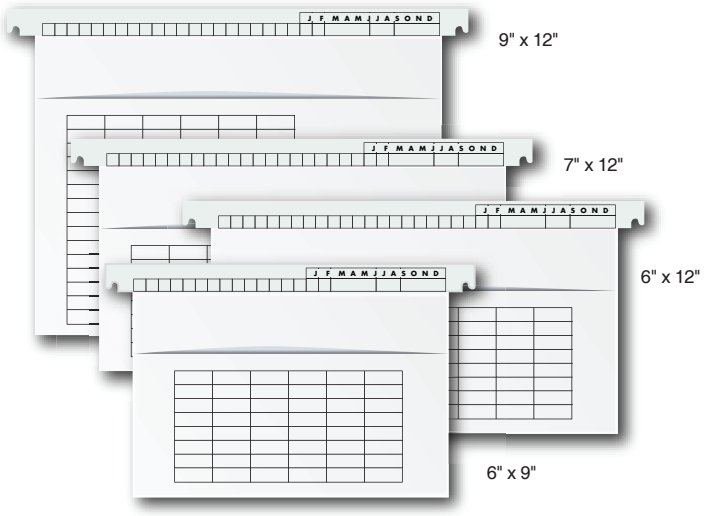


PANOREX ENVELOPES

6.5" x 12.75"

Quantity	100	250	500	1000
Blank	47.00	92.00	175.00	270.00
Personalized	105.00	150.00	235.00	350.00

Prices are subject to change

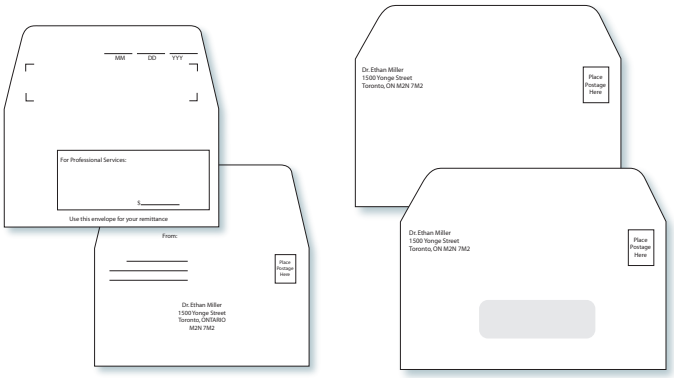


Our durable hanging file pouches, made with sturdy, gloss card stock, are available in four different sizes.

FILING SYSTEMS - HANGING POUCHES

6" x 9", 6" x 12", 7" x 12", 9" x 12" - 9" Hanger, 12" Hanger. Printed on 14pt. gloss stock

Quantity	100	500	1000
6" x 9"	28.00	133.00	250.00
6" x 9" expandable	43.00	200.00	375.00
6" x 12"	32.00	140.00	265.00
7" x 12"	44.00	194.00	315.00
9" x 12"	48.00	210.00	390.00
9" Hanger	40.00	172.00	308.00
12" Hanger	42.75	195.00	350.00



STATEMENT AND COLLECTION ENVELOPES

#8 - 3.63" x 6.5", #8.5 - 3.75" x 6.75" - Printed with black ink

Quantity	500	1000
Statement/Collection Envelope 16A2, 18A17	215.00	280.00
#8 Return Envelope		
#8 Window Envelope		
#8.5 Return Envelope	*Prices Available on Request*	
#8.5 Window Envelope		

Prices are subject to change

ORTHODONTIC CHARTS AND FORMS

DATE	SERVICE PERFORMED	NEXT

ORTHODONTIC DIAGNOSIS CHART

NAME _____ ADDRESS _____
DATE _____ 20 ____ CASE No _____ AGE _____ BIRTHDAY _____
PARENT _____ PHONE _____ BUS. PHONE _____
REFERRED BY _____ PHYSICIAN _____
DENTIST _____ ADDRESS _____
REASON FOR PRESENTATION _____
PREV. ORTHO. _____
GRADE _____ SCHOOL _____ STANDING _____
HERED. FACTORS _____
ENVIRONMENT FACTORS _____
HABITS _____
OPERATIONS, TRAUMA _____
CHILD. DISEASES _____ PRESENT HEALTH _____
MEDICAL HISTORY _____
BREATHING _____ T & A REM. _____ MATURATION _____
ALLERGIES: HIVES _____ HAY FEVER _____ OTHERS _____
PATIENT INT. & COOP. _____
REMARKS: _____

1. SOFT TISSUE
Profile
Facial Type
Symmetry
Lips
Esthetics
Gingivae
Frenae
General Tone
Tongue

2. DENTAL CLASSIFICATION
Molar
Cuspid
Overbite
Crossbite
Midline
Caries Exp.
Widths
TP
Overjet
O.H.

Prem Loss
Req'd. Avail Ant
=

Other Obs:

Apical Base-
3. FUNCTIONAL ANAL:
Path of closure
Freeway
T.M.J.
Deglutition
4. MODEL ANAL:

5. RADIOGRAPHIC
Profile
Facial Type
Skel Patt

Supernumerary
Supplemental
Missing
Apices
6. DIAGNOSIS

7. TREATMENT PLAN

8. PROGNOSIS

9. EST. TIME OF TREATMENT:

10. REMARKS:

Orthodontic Diagnosis Chart

DATE	SERVICE PERFORMED	TIME	NEXT APPOINTMENT

ORTHODONTIC CASE ANALYSIS

Exam Date _____
Records _____
Consultation _____

NAME _____ ADDRESS _____
CITY _____ POSTAL CODE _____ HOME PHONE _____
PARENT _____ BUS ADDRESS _____ BUS. PHONE _____
REFERRED _____ DENTIST _____ PHYSICIAN _____
AGE ____ BIRTHDATE ___ /___ /___ SCHOOL _____ GRADE _____
REASON FOR PRESENTATION _____
DENTAL INSURANCE: Yes ☐ No ☐ If yes, COMPANY _____
EMPLOYER _____ GROUP NO. _____ PLAN NO. _____

MEDICAL HX _____
DENTAL HX _____
HABITS _____
HOBBIES AND INTERESTS _____

SOFT TISSUE ANALYSIS
Facial Type R ___ O ___ P _____
Profile Type C'vex ___ S ___ C'cave _____
Esthetics G ___ F ___ P _____
Lip Tonicity Hyper ____ N ____ Hypo _____
Lip Length S ____ N ____ L _____
Lips at Rest Apart ____ Contact _____
Frenum Neg ___ Q ____ Pos _____
Tongue Size S ____ N ____ L _____
LAFH S ____ N ____ L _____
Nasolabial Angle Ob ____ N ____ Ac _____

FUNCTIONAL ANALYSIS
Freeway Space S ____ N ____ L _____
TMJ Symp ____ (L ____ R ____) Neg _____
Prematurities _____
Closure Path _____
Deglutition _____
Speech _____
Lip form Evert ____ N ____ Redund _____
Lower lip entrap Y ___ N ___
Tongue Thrust N ____ Y ____ (ant ___ post ___)
Symmetry Mx. ____ Y ____ N _____
Md. ____ Y ____ N _____

CEPHALOMETRIC ANALYSIS
SNA _____ Mx. UL ____ mm
SNB _____ Md. UL ____ mm
ANB _____
GOGNSN _____ Md-Mx diff ____ mm
1 - 1 _____
1 - MP _____ LAFH _____
1 - NA _____
1-AP ____ mm _____

BURLINGTON ANALYSIS
A. Size of Facial Components
I. CRANIAL BASE — Ant. (Nasion) _____ Post. (Bolton) _____ Upper F.H. (N-ANS)_____
II. FACE HEIGHT — Lower F.H. (ANS-Me) _____
III. MAXILLA — A-P position A Pt._____ Sup.-Inf. position A Pt._____ A-P position mesial 6 6_____ Sup.-Inf. position mesial 6 6 _____ (Max. Ht.)
IV. MANDIBLE — A-P position B Pt. _____ Sup.-Inf. height of Md. _____ (LFH-Max. Ht.)

B. Harmony of Skeletal Components

	MAX.	MAN.
S-C		
S-PTM		
Max.		
Man.		
TOTAL		

DENTAL ANALYSIS
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
E D C B A | A B C D E
E D C B A | A B C D E
OJ ____ mm ____OB ____% Imp._____
X-bite
Molar class R ____ L _____
Cuspid class R ____ L _____
Crowding/Spacing Mx ___ mm ___ Md ___ mm
Spee N ____ Ex _____
Diastema _____
Arch Width Mx. Ex ___ N ____ Con ____
Md. Ex ___ N ____ Con ____
Midline Mx. R ____ mm N ____ L ____ mm
Md. R ____ mm N ____ L ____ mm
Axial Inclination
Mx. in Pro ___N ____ Retro _____
Md. in Pro ___N ____ Retro _____
Decalcif _____
Oral Hygiene G ____ F ____ P _____

MATURATION
Physical Devel Del ___ N ____ Adv _____
Dental Devel Del ___ N ____ Adv _____

DIAGNOSIS

TREATMENT OBJECTIVES

TREATMENT PLAN
___ Observation ___ yr(s) ____ M
___ Records ____ M ____ C ____ P _____
___ Non-Ex
___ Ext.
___ Hgdr Cerv.____HiPull ____Comm ____
___ Lip Bump
___ Elastics C1 I____Cl II ____Cl III ____
___ Full-Band
___ Partial Rx
___ Surg Jaw ____ Soft T ____Tooth Exp ____
___ Exp. Appl
___ Removable Appl _____
___ Other _____

PROGNOSIS & EST Rx TIME

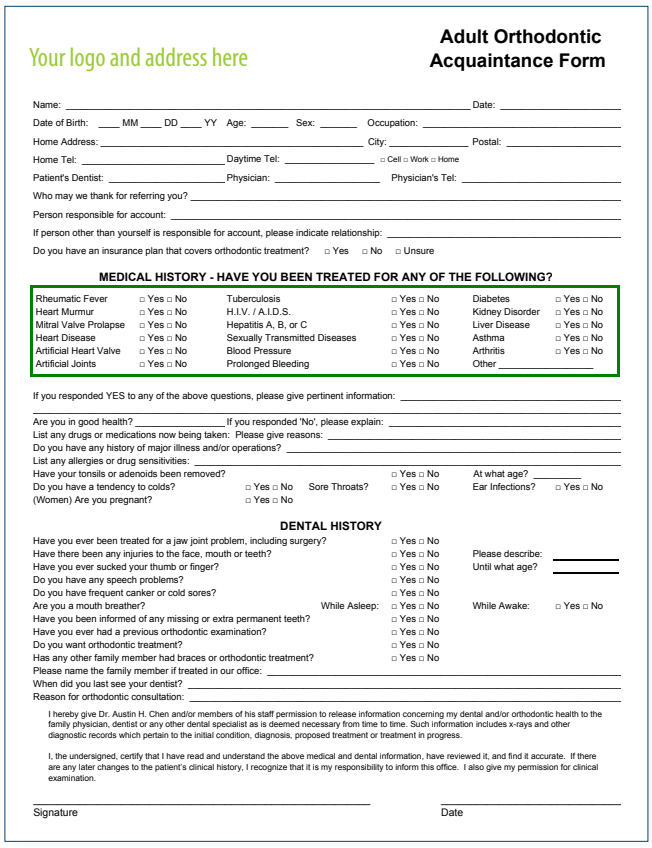
INDIC FEE
Total _____
Initial _____
Monthly _____
Quarterly _____
Other _____

ORAL HYGIENE G F P
Instruction
Sessions

RETENTION
3 to 3
Hawley
Hdgr.
OTHER _____

COMMENTS

Orthodontic Case Analysis Chart



Your logo and address here

Adult Orthodontic Acquaintance Form

Name: _____ Date: _____

Date of Birth: ___ MM ___ DD ___ YY Age: _____ Sex: _____ Occupation: _____

Home Address: _____ City: _____ Postal: _____

Home Tel: _____ Daytime Tel: _____ □ Cell □ Work □ Home

Patient's Dentist: _____ Physician: _____ Physician's Tel: _____

Who may we thank for referring you? _____

Person responsible for account: _____

If person other than yourself is responsible for account, please indicate relationship: _____

Do you have an insurance plan that covers orthodontic treatment? □ Yes □ No □ Unsure

MEDICAL HISTORY - HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING?

Rheumatic Fever	□ Yes □ No	Tuberculosis	□ Yes □ No	Diabetes	□ Yes □ No
Heart Murmur	□ Yes □ No	H.I.V. / A.I.D.S.	□ Yes □ No	Kidney Disorder	□ Yes □ No
Mitral Valve Prolapse	□ Yes □ No	Hepatitis A, B, or C	□ Yes □ No	Liver Disease	□ Yes □ No
Heart Disease	□ Yes □ No	Sexually Transmitted Diseases	□ Yes □ No	Asthma	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Blood Pressure	□ Yes □ No	Arthritis	□ Yes □ No
Artificial Joints	□ Yes □ No	Prolonged Bleeding	□ Yes □ No	Other _____	

If you responded YES to any of the above questions, please give pertinent information: _____

Are you in good health? _____ If you responded 'No', please explain: _____

List any drugs or medications now being taken: Please give reasons: _____

Do you have any history of major illness and/or operations? _____

List any allergies or drug sensitivities: _____

Have your tonsils or adenoids been removed? □ Yes □ No At what age? _____

Do you have a tendency to colds? □ Yes □ No Sore Throats? □ Yes □ No Ear Infections? □ Yes □ No

(Women) Are you pregnant? □ Yes □ No

DENTAL HISTORY

Have you ever been treated for a jaw joint problem, including surgery?	□ Yes □ No		
Have there been any injuries to the face, mouth or teeth?	□ Yes □ No	Please describe:	
Have you ever sucked your thumb or finger?	□ Yes □ No	Until what age?	
Do you have any speech problems?	□ Yes □ No		
Do you have frequent canker or cold sores?	□ Yes □ No		
Are you a mouth breather? While Asleep:	□ Yes □ No	While Awake:	□ Yes □ No
Have you been informed of any missing or extra permanent teeth?	□ Yes □ No		
Have you ever had a previous orthodontic examination?	□ Yes □ No		
Do you want orthodontic treatment?	□ Yes □ No		
Has any other family member had braces or orthodontic treatment?	□ Yes □ No		

Please name the family member if treated in our office: _____

When did you last see your dentist? _____

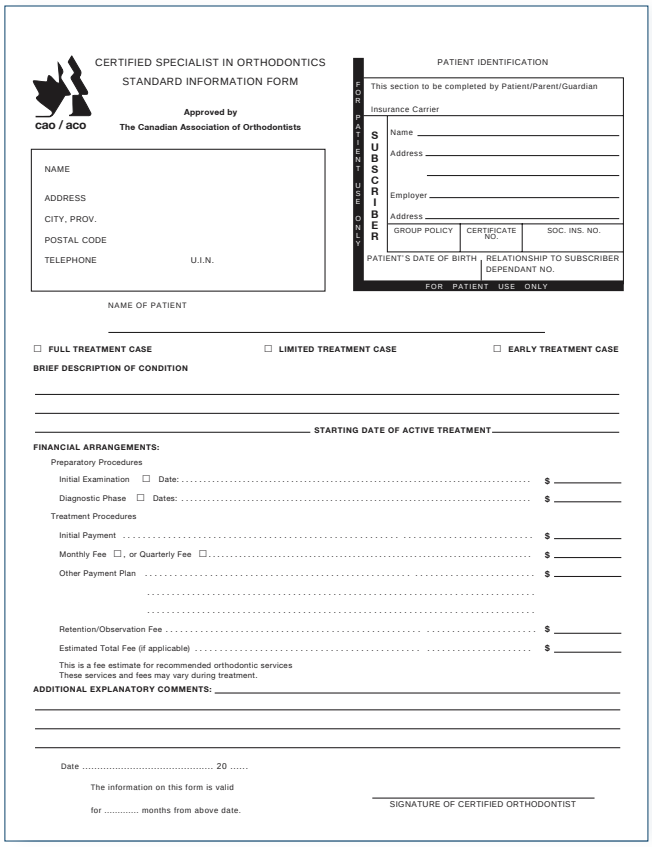
Reason for orthodontic consultation: _____

I hereby give Dr. Austin H. Chen and/or members of his staff permission to release information concerning my dental and/or orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary from time to time. Such information includes x-rays and other diagnostic records which pertain to the initial condition, diagnosis, proposed treatment or treatment in progress.

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for clinical examination.

Signature _____ Date _____

Adult Orthodontic Aquaintance Form 8.5" x 11"



CERTIFIED SPECIALIST IN ORTHODONTICS

STANDARD INFORMATION FORM

cao / aco

Approved by

The Canadian Association of Orthodontists

NAME

ADDRESS

CITY, PROV.

POSTAL CODE

TELEPHONE U.I.N.

PATIENT IDENTIFICATION

FOR PATIENT USE ONLY

This section to be completed by Patient/Parent/Guardian

Insurance Carrier

SUBSCRIBER

Name

Address

Employer

Address

GROUP POLICY | CERTIFICATE NO. | SOC. INS. NO.

PATIENT'S DATE OF BIRTH | RELATIONSHIP TO SUBSCRIBER DEPENDANT NO.

FOR PATIENT USE ONLY

NAME OF PATIENT _____

□ FULL TREATMENT CASE □ LIMITED TREATMENT CASE □ EARLY TREATMENT CASE

BRIEF DESCRIPTION OF CONDITION

STARTING DATE OF ACTIVE TREATMENT _____

FINANCIAL ARRANGEMENTS:

Preparatory Procedures

Initial Examination □ Date: ..... $ _____

Diagnostic Phase □ Dates: ..... $ _____

Treatment Procedures

Initial Payment ..... $ _____

Monthly Fee □, or Quarterly Fee □ ..... $ _____

Other Payment Plan ..... $ _____

Retention/Observation Fee ..... $ _____

Estimated Total Fee (if applicable) ..... $ _____

This is a fee estimate for recommended orthodontic services
These services and fees may vary during treatment.

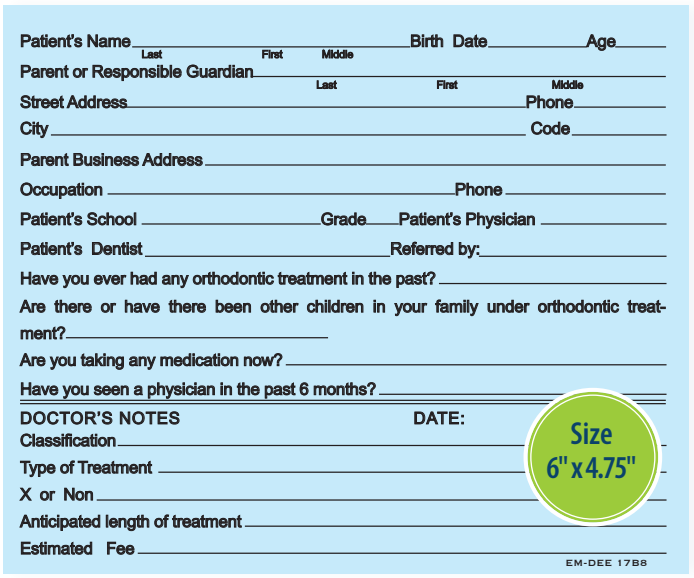
ADDITIONAL EXPLANATORY COMMENTS: _____

Date ..... 20 .....

The information on this form is valid for ..... months from above date.

SIGNATURE OF CERTIFIED ORTHODONTIST

CSO Standard Info Form



Patient's Name _____ Birth Date _____ Age _____
Last First Middle

Parent or Responsible Guardian _____
Last First Middle

Street Address _____ Phone _____

City _____ Code _____

Parent Business Address _____

Occupation _____ Phone _____

Patient's School _____ Grade _____ Patient's Physician _____

Patient's Dentist _____ Referred by: _____

Have you ever had any orthodontic treatment in the past? _____

Are there or have there been other children in your family under orthodontic treatment? _____

Are you taking any medication now? _____

Have you seen a physician in the past 6 months? _____

DOCTOR'S NOTES DATE:

Classification _____

Type of Treatment _____

X or Non _____

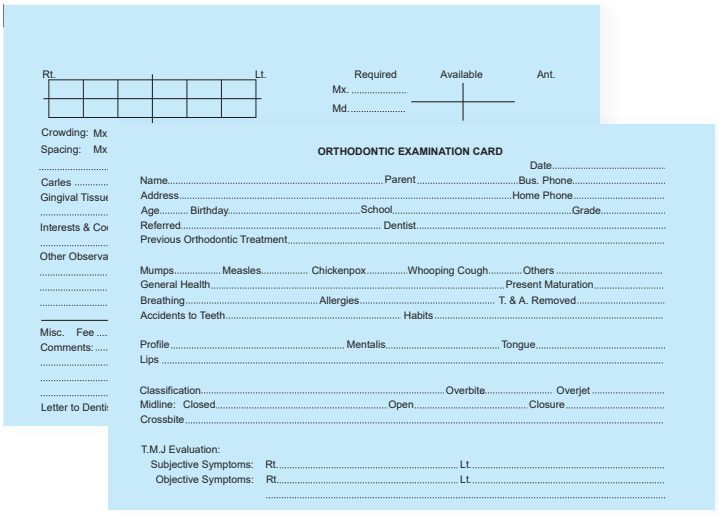
Anticipated length of treatment _____

Estimated Fee _____

Size 6" x 4.75"

EM-DEE 17B8

no. 17B8 - Orthodontic Patient Registration and History Card
6"x 4.75", printed on 110lb blue cover with black ink



Rt. Lt.

Required Available Ant.

Mx.

Md.

Crowding: Mx

Spacing: Mx

Carles

Gingival Tissue

Interests & Co

Other Observa

Misc. Fee

Comments:

Letter to Dentis

ORTHODONTIC EXAMINATION CARD

Date

Name Parent Bus. Phone

Address Home Phone

Age Birthday School Grade

Referred Dentist

Previous Orthodontic Treatment

Mumps Measles Chickenpox Whooping Cough Others

General Health Present Maturation

Breathing Allergies T. & A. Removed

Accidents to Teeth Habits

Profile Mentalis Tongue

Lips

Classification Overbite Overjet

Midline: Closed Open Closure

Crossbite

T.M.J Evaluation:

Subjective Symptoms: Rt. Lt.

Objective Symptoms: Rt. Lt.

Orthodontic Examination Card
8" x 5", printed on 110lb blue chart stock with black ink

CSO ORTHO INFO FORMS

Quantity	250	500	1000	2000
Single Sheets	85.00	120.00	165.00	240.00
2 Part NCR	145.00	215.00	290.00	460.00
3 Part NCR	165.00	245.00	375.00	590.00

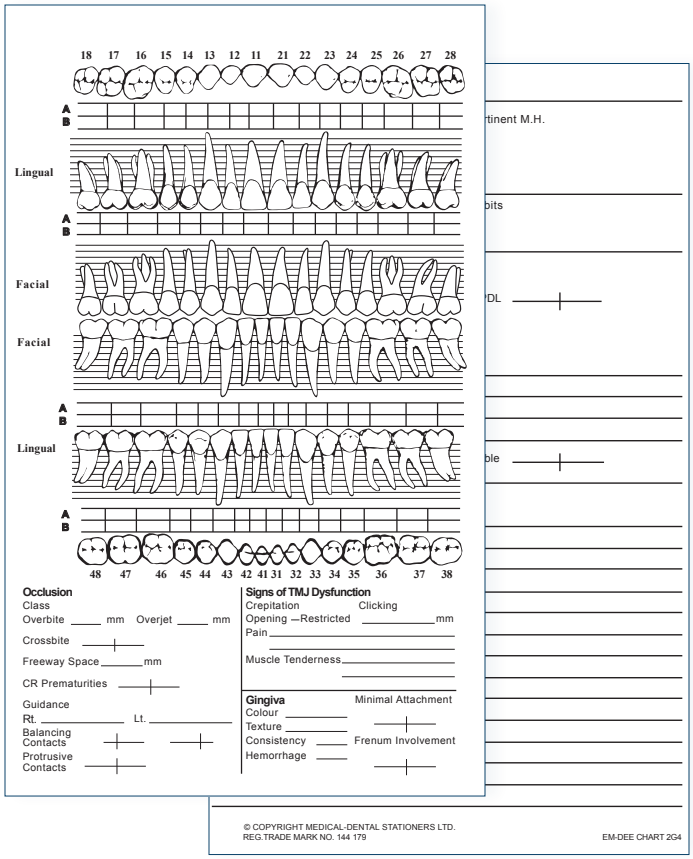
Prices are subject to change

ORTHODONTIC CHARTS AND FORMS

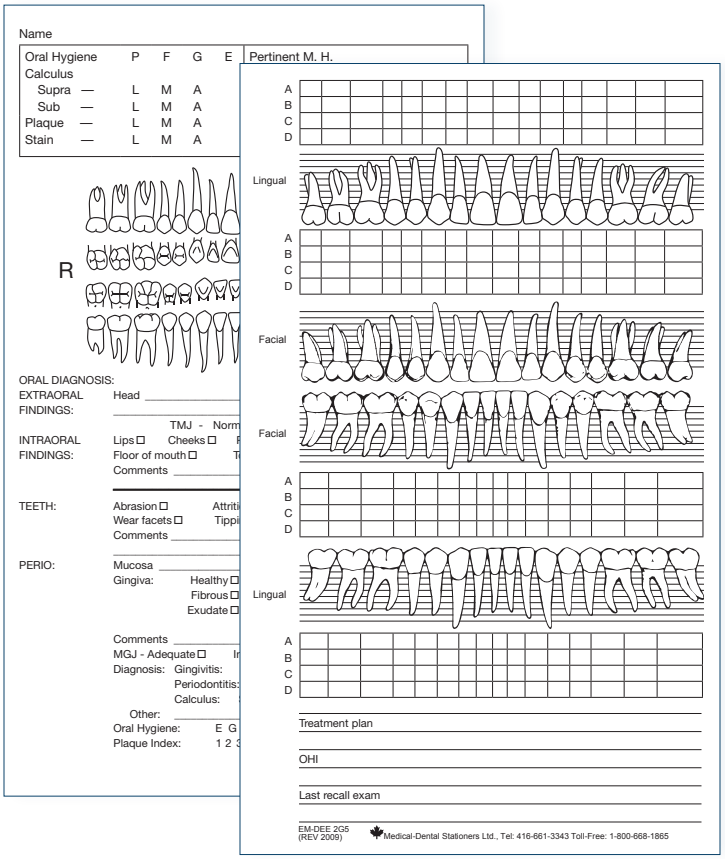
Quantity	250	500	1000	2000
Diagnosis Chart, 8.5" x 11", DS	150.00	205.00	290.00	470.00
Case Analysis Chart 8.5" x 11", DS	125.00	180.00	275.00	435.00
Adult Aquaintance Form 8.5" x 11", SS	80.00	105.00	130.00	185.00
Ortho Exam Card, 8" x 5", DS	92.00	115.00	160.00	240.00
Patient Registration & History Card	90.00	105.00	130.00	190.00

Prices are subject to change

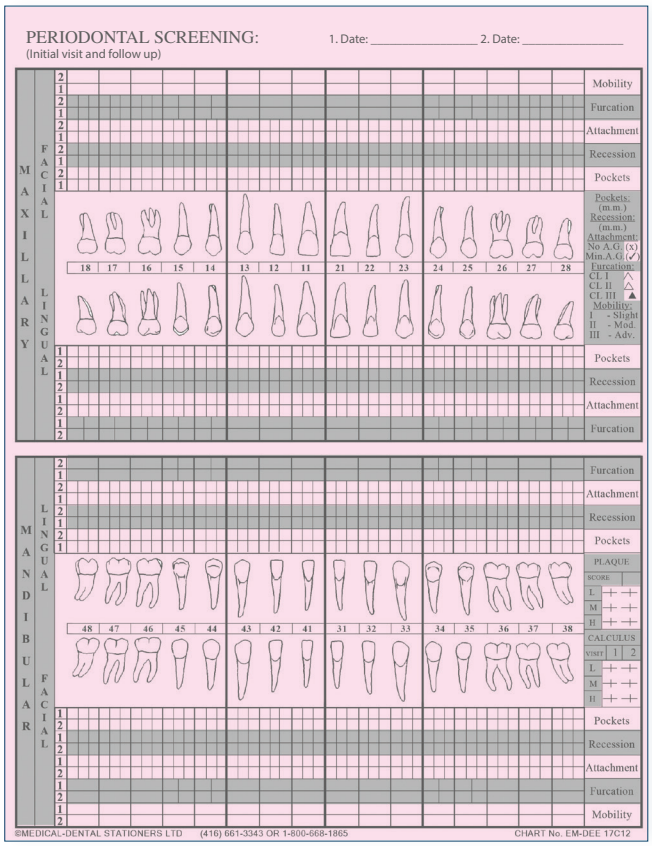
PERIODONTIC CHARTS



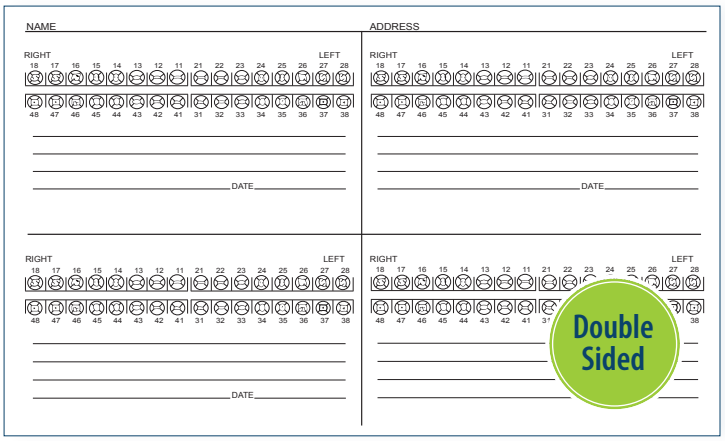
no. 2G4 - Periodontic Chart 5" x 8", printed on 110lb white chart stock with black ink



no. 2G5 - Periodontic Chart, 5" x 8", printed on 110lb white chart stock with black ink



no. 17C12 - Periodontic Exam Chart, single-sided, 8.5" x 11", 20lb pink bond, black ink.

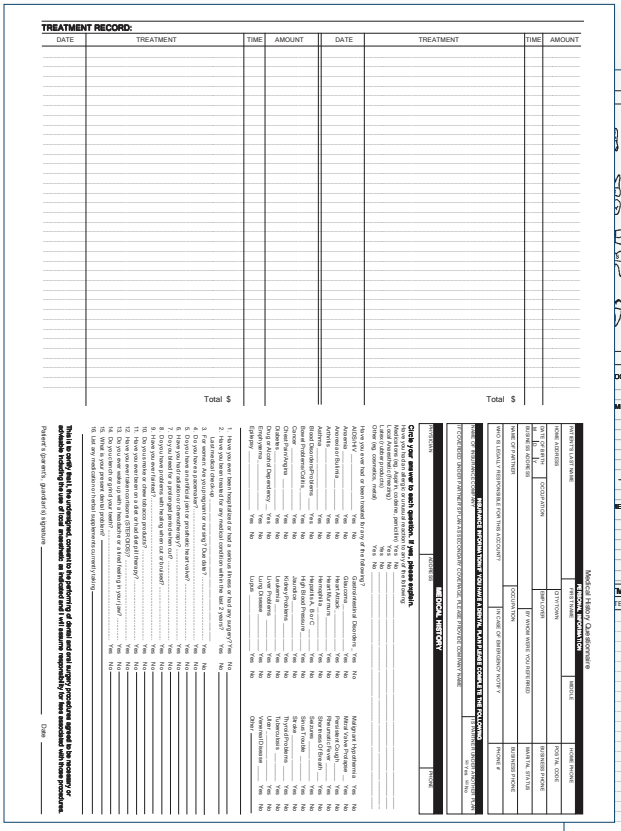


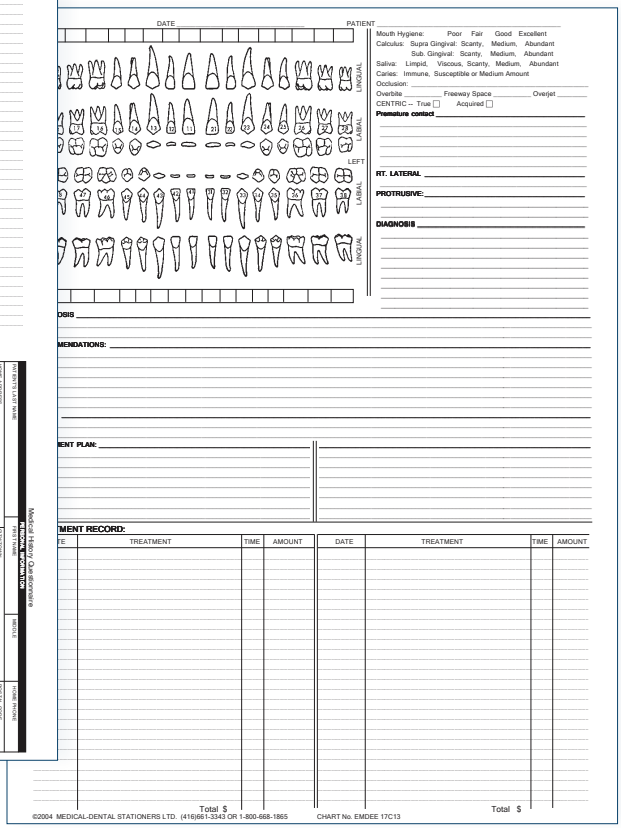
no. 17A2 - Periodontic Recall Chart, 8" x 5" - printed 2 sided on 110lb chart stock with black ink

PERIODONTIC CHARTS

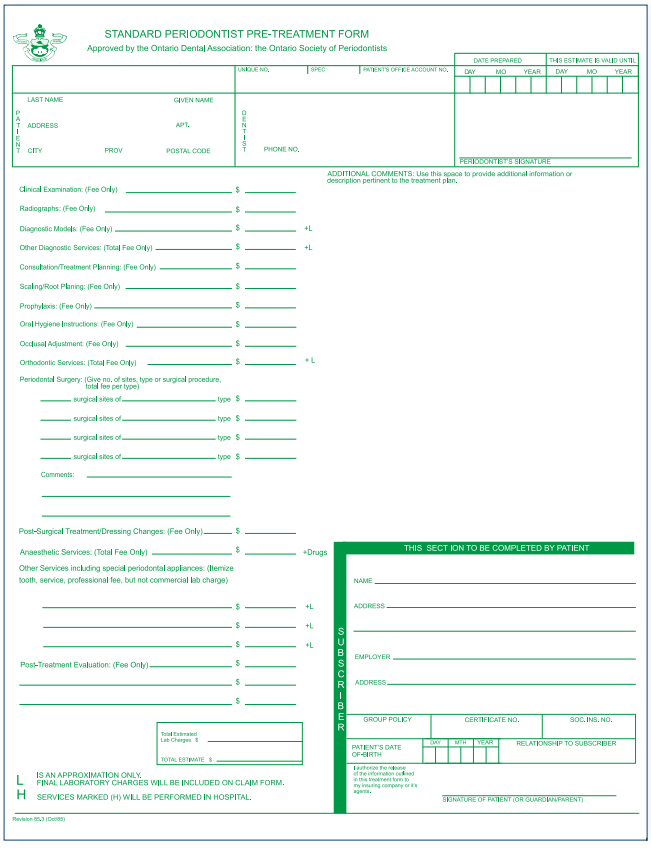
Quantity	250	500	1000	2000
2G4 - Perio Chart, 5" x 8", DS	77.00	105.00	140.00	225.00
2G5 - Perio Chart, 5" x 8", DS	77.00	105.00	140.00	225.00
17C13 -Treatment Chart, 10" x 14", DS	130.00	190.00	275.00	460.00
17C12 - Exam Chart, 8.5"x 11", SS, pink bond	65.00	85.00	125.00	225.00
17A2 - Recall Chart, 8"x 5", DS, 110lb chart stock	77.00	105.00	140.00	225.00

Prices are subject to change





no. 17C13 - Periodontic Treatment Chart - 10″ x 14″
printed on 24lb white bond with black ink. Scored.



Standard Periodontic Pretreatment Form, 8.5″ x 11″, single sided

PERIODONTIC PRETREATMENT FORMS

Quantity	250	500	1000	2000
Single Sheet - Blank	45.00	60.00	95.00	145.00
Single Sheet - Imprinted	129.00	140.00	175.00	225.00
2 Part Carbonless Blank	78.00	105.00	180.00	320.00
2 Part Carbonless - Imprinted	150.00	205.00	270.00	445.00
3 Part Carbonless Blank	115.00	135.00	245.00	475.00
3 Part Carbonless - Imprinted	175.00	235.00	350.00	605.00

Prices are subject to change

ENDODONTIC CHARTS

ENDODONTIC CASE HISTORY

AGE NAME YEAR
Mr. ☐
Miss ☐ ADDRESS
PATIENT: Mrs. ☐ ZONE
(Print)

REFERRED BY DR.
PHONE NO.

HOME PHONE: OCCUPATION: BUS. PHONE:
A record of previous endodontic case history for this patient TEETH INVOLVED NO. OF CANALS:
will be found under YEAR FILE CHART FILE NO. CHART NO.:

1. DENTAL COMPLAINT

PAST	PRESENT
☐ NONE	☐
☐ PAIN TO HEAT	☐
☐ PAIN TO COLD	☐
☐ PAIN TO PRESSURE	☐
☐ TOOTHACHE	☐

2. CLINICAL EXAMINATION

EXCESSIVE MOBILITY ☐
DRAINING SINUS ☐
DISCOLOURATION ☐
CROWN FRACTURE ☐
ROOT FRACTURE ☐
PAIN TO PERCUSSION ☐
PAIN TO HEAT ☐
PAIN TO COLD ☐
CARIES ☐
RESTORATION ☐
SWELLINGS:
INTRA ORAL ☐
EXTRA ORAL ☐
HARD ☐
SOFT ☐
TENDERNESS TO PRESSURE ☐
CRACKLING ☐
LYMPH ADENITIS ☐
(Name)

3. ELECTRICAL PULP TEST:

Date	Reading	Control Tooth	Reading

4. RADIOGRAPHIC E
NORMAL
APICAL RAREFA
LATERAL RARE
CONDENSING O
INCOMPLETE R
INTERNAL RES
EXTERNAL RES
CALCIFICATION
ROOT FRACTUR

5. ETIOLOGY:
CARIOUS EXPO
INSTRUMATIC E
TRAUMATIC EX
EXTENSIVE FIL
TRAMATIC OCC
TRAUMA

MEDICAL HISTORY:
RHEUMATIC FEVER ☐ DIABETES ☐ HEPATITIS ☐
JAUNDICE ☐ T.B. ☐ NEPHRITIS ☐

DEPTH OF INSTRUMENTATION	Largest File Number Used	Date	Drugs Sealed in Canal	Culture	Pos.	Neg.	Date Reading
SINGLE CANAL							
M.B. CANAL							
D.B. CANAL							
M.L. CANAL							
LINGUAL							
BUCCAL							
DISTAL							

DATE CANAL(S) FILLED:
CANAL(S) FILLED WITH:

*MARK C IN APPROPRIATE COLUMN ON DATE WHEN CULTURE TAKEN.

PERIAPICAL CURETTAGE: DATE:
TEETH INVOLVED:
ANAESTHETIC (Type): NO. C.C.
SITE:
PREMEDICATION:
POSTMEDICATION:
APICAL FINDINGS:

BIOPSY REPORT NO.:

EM-DEE No. ENDO 2

DATE RECALL RECORD

SUCCESS (YEARS) FAILURE

1	2	3	4	5		1	2	3	4	5	
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

no. Endo2 - 8" x 5" double-sided

ENDODONTIC CASE HISTORY

PATIENT: YEAR
STREET MONTH
MUNICIPALITY ZONE DAY

REFERENCE
DR.

HOME PHONE: BUS. PHONE:
A record of previous endodontic case history for this patient TEETH INVOLVED
will be found under YEAR FILE CHART FILE NO. CLAMP NO.:

DENTAL COMPLAINT

ELECTRICAL PULP TEST:

Tooth Date	Reading	Control Tooth	Reading

MEDICAL HISTORY:

CLINICAL EXAMINATION

RADIOGRAPHIC EX

FILM NO.

GENERAL DATA

DEPTH OF INSTRUMENTATION	Largest File Number Used	Date	Drugs Sealed in Canal	Culture	Pos.	Neg.	Date Reading
SINGLE CANAL							
M.B. CANAL							
D.B. CANAL							
M.L. CANAL							
LINGUAL							
BUCCAL							
DISTAL							

DATE CANAL(S) FILLED:
CANAL(S) FILLED WITH:

DATE REPORTED MAILED ☐ PHONED ☐

PERIAPICAL SURGERY RECORD: DATE:
TEETH INVOLVED:
ANAESTHETIC (Type):
SITE:
PREMEDICATION:
POSTMEDICATION:
APICAL FINDINGS:

BIOPSY REPORT NO.:

DATE RECALL RECORD REPORT MAILED

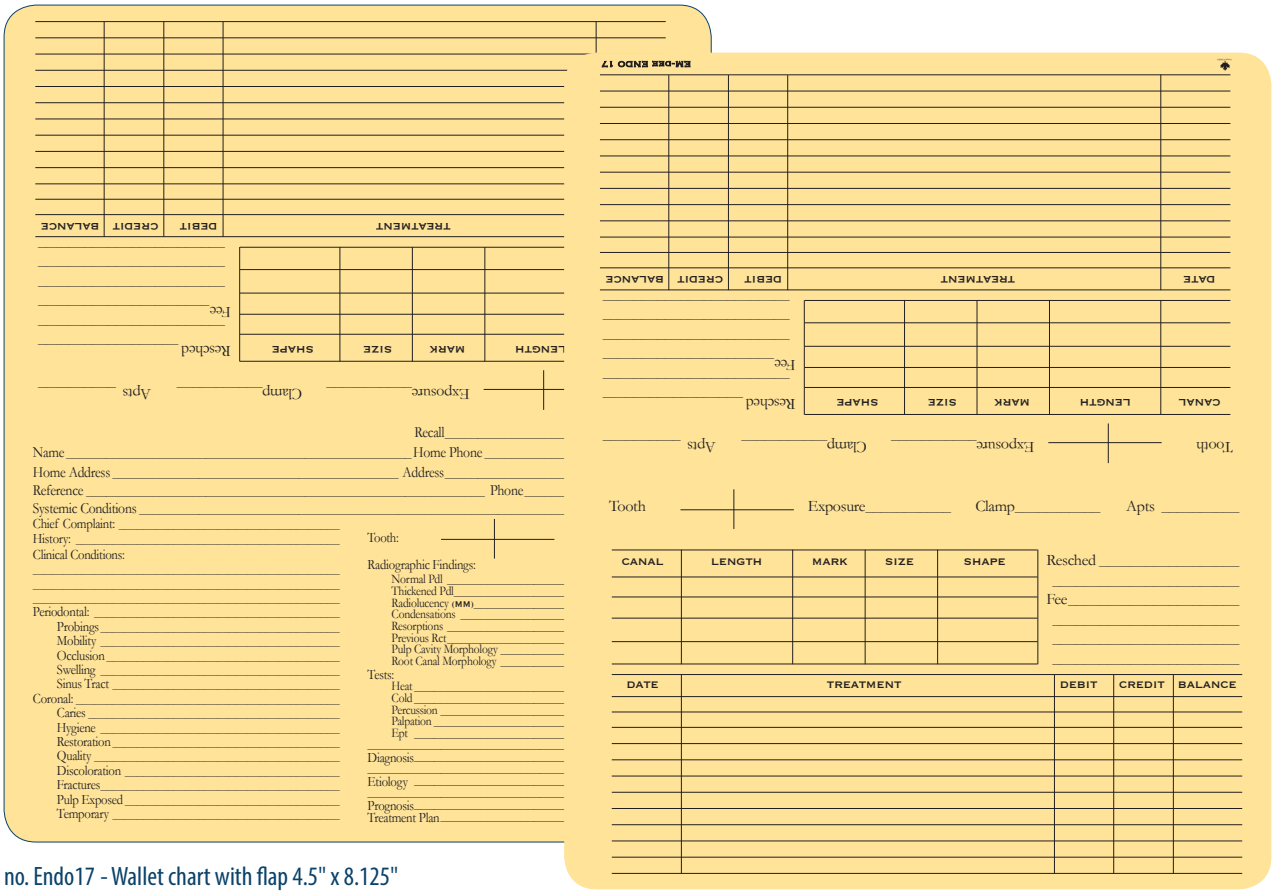
no. Endo5 - 8" x 5" double-sided

ENDODONTIC CHARTS

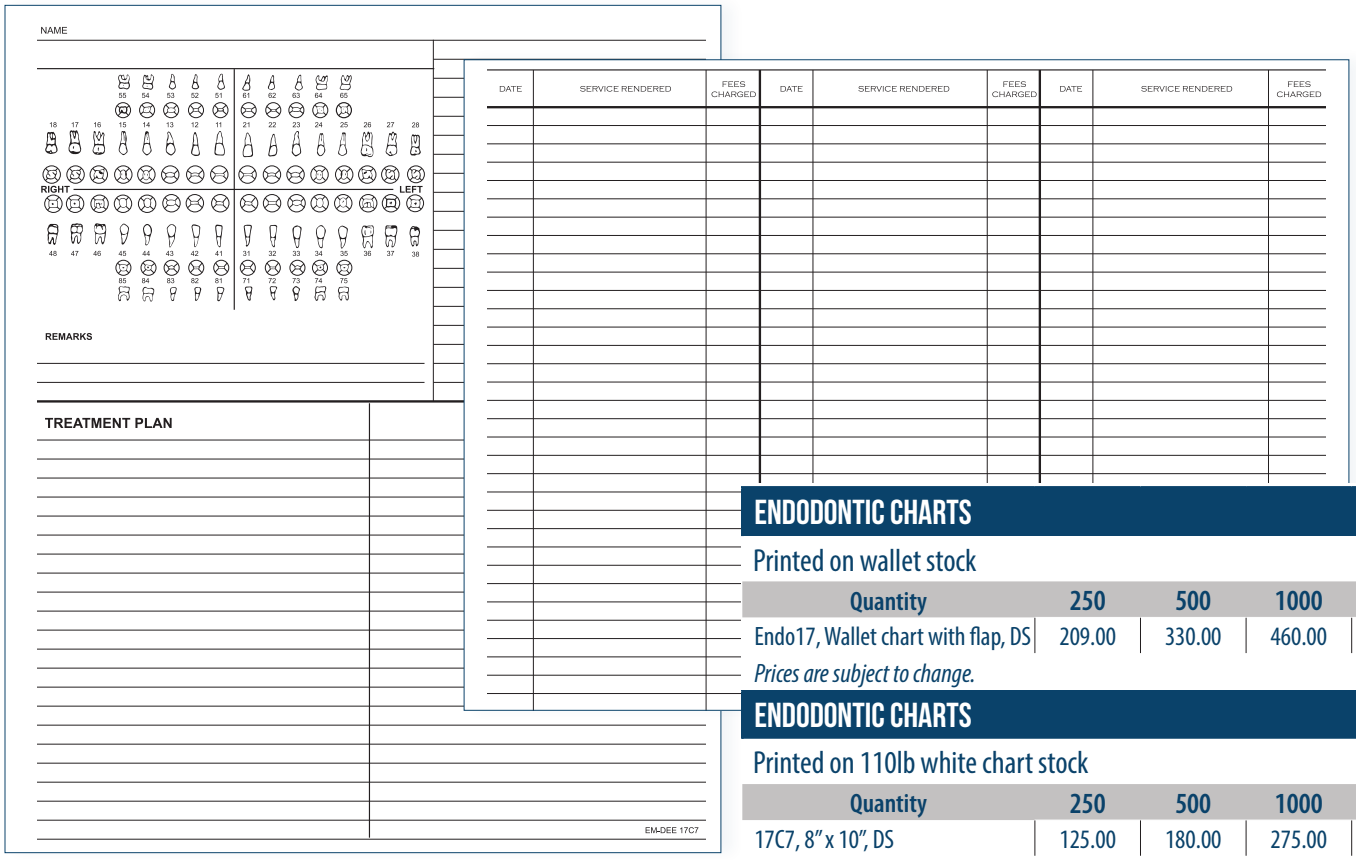
Printed on 110lb white chart stock

Quantity	250	500	1000	2000
Endo2, 8" x 5", DS	77.00	105.00	140.00	225.00
Endo5, 8" x 5", DS	77.00	105.00	140.00	225.00

Coloured stock available at extra charge. Prices are subject to change.



no. Endo17 - Wallet chart with flap 4.5" x 8.125"



no. 17C7 - Periodontic Screening Chart - 8" x 10" double-sided

ENDODONTIC CHARTS

Printed on wallet stock

Quantity	250	500	1000	2000
Endo17, Wallet chart with flap, DS	209.00	330.00	460.00	780.00

Prices are subject to change.

ENDODONTIC CHARTS

Printed on 110lb white chart stock

Quantity	250	500	1000	2000
17C7, 8" x 10", DS	125.00	180.00	275.00	435.00

Coloured stock available at extra charge. Prices are subject to change.

MEDICAL DENTAL
STATIONERS LTD.

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Order by Phone: Local **416.661.3343** or toll free**1.800.668.1865**
Order by Email: medicaldental@communicationalliance.com
You will receive an e-mail notification to confirm that your order has been received. If you do not receive a notification within 72 hours, please call us back during regular business hours.
Order by Fax: Fax your completed order form to **416.299.1530**
Our Hours: Monday to Friday 9am - 5pm (EST). Payment for phone orders can be made with Visa or MasterCard credit cards. Please have your credit card information ready when ordering.
Pick-Up Orders: You can pick up your orders Monday through Friday between 9am and 5pm from our office located at **30 Rolark Drive, Toronto, ON M1R 4G2**. Please indicate this when placing your order so that no shipping charge will be added to your account.

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Credit Card: Payments by Visa or MasterCard are accepted prior to shipments when ordering. Please provide the credit card number, expiration date and name of cardholder.
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Our talented design team will be happy to recreate your existing design for you. A physical sample of your document is recommended to accurately match your design layout and stock preference. Recreation fees will vary. Additional charges apply for recreations of logos. Electronic logos are preferred. Should electronic artwork not be provided, our designers will use their professional judgment on typestyle and composition. Additional fees may apply.

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Supplying us with the proper artwork files helps us process your order faster.
Preferred Artwork Format: Vector art with file extensions .eps and .ai are preferred. Vector art can be easily resized or coloured and image quality will stay the same. Programs used to create vector art: Adobe Illustrator, Adobe inDesign.
Production Ready Files & Preferred File Types: High resolution PDF, EPS or Adobe CC or lower.
Image Resolution: 300 dpi at actual size. Lower resolution files may be used but the print quality may vary. Artwork used for the internet is scanned at low resolution and is meant for viewing on-screen only. These images are scanned at 72dpi and are not meant for printing reproduction.
Image Colour: RGB and CMYK are acceptable. PMS matching may result in additional fees.
Submission Format: E-mail files under 10MB to medicaldental@communicationalliance.com. Files over 10MB can be uploaded to our FTP server (contact us for further information), or supplied on a CD or USB Drive. Production ready PDF's must be created to our specification to ensure compatibility with our processes.

Please contact our Service Representatives at **416.661.3343** or **1.800.668.1865** should you have any further questions.
email: medicaldental@communicationalliance.com
web: www.medicaldentalstationers.com

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MEDICAL DENTAL STATIONERS LTD.

For Internal Use Only

CRM:_____

OE#: _____

DD: _____

REP: _____

ORDER FORM

To place your order, photocopy, complete and fax the order form to the number below. If you prefer to place your order by phone, photocopy the order form to collect your order information before calling or keep it for your records. Standard turn around time for print orders is 7 business days from the time that art is approved.

NEW FAX#

Phone: 416.661.3343 or Toll Free:1.800.668.1865 or Fax: 416. 299.1530

CONTACT INFO

Practitioner's Name:		Clinic Name		Date:
Address:		City	Province:	Postal Code:
Phone:	Fax:	Email:		Contact:

BILLING INFORMATION

☐ Same as Contact info ☐ Use Address Below

_____

_____

_____

Payment Method: ☐ Visa ☐ MC ☐ Amex ☐ Please Bill

Card: _____ Expiry_____

Name on Card: _____

PROOF METHOD

Our representatives will send you a proof of any first-time product orders.

Send me a proof by: ☐ Fax ☐ E-mail ☐ Paper Proof ($5.00)

DS = double sided print

SS = single sided print

STATIONERY

Product Code	Product Description / Details	Size	Finish Gloss / Matte	Quantity	Total

If no options are selected, 10pt Matte with white paper & black ink will be selected (unless full colour card is chosen)

APPOINTMENT CARDS & MAGNETS

Product Code	Product Description / Details	Indicate Cancellation Policy 24h, 48hr, 72hr	Finish Gloss / Matte	Quantity	Total

If no options are selected, 10pt Matte with white paper & black ink will be selected (unless full colour card is chosen)

CHARTS & FORMS

Product Code	Product Description / Details	Chart Paper or Standard Paper	Size	Quantity	Total

If no options are selected, 10pt Matte with white paper & black ink will be selected (unless full colour card is chosen)

MEDICAL DENTAL
STATIONERS LTD.

ORDER FORM

SPECIAL INSTRUCTIONS

Please indicate any special instructions for your order. This information may include: specialty paper, address changes, specific font choices, custom messages or instructions for our team.

Ordering Information
If you have questions or would like to place your order by phone, call **416.661.3343** or our toll-free number: **1.800.668.1865** weekdays 9am to 5pm EST. You may also email your order directly to **medicaldental@communicationalliance.com.** You will receive an email notification from one of our sales reps to confirm that your order has been received. If you do not receive a notification within 72 hours, please call back during business hours. Payment for phone orders, fax and email orders may be made with a Visa or MasterCard credit card or invoice with net 30 day terms. Please have your credit card information ready when calling. Should there be any inclarity or discrepancy in your order form, a representative will contact you to clarify detail.

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Please be sure your order is correct and final before mailing to us. We cannot guarantee to intercept, cancel or change any order that has been sent or phoned to us and has been placed into production. At your request we will attempt to locate such orders. If we stop your order you will be charged in proportion to the work completed (minimum charge $10.00). If the order is completed you will be charged full cost.

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☐ Yes! Contact me with an order confirmation within 72 hours

☐ Please proceed with my order as instructed on the order form. I understand if there are any questions, a sales person will contact me.

Name (print)

Signature

Date

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