

## ORDER FORM

Dr: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Fax #: \_\_\_\_\_  
 E-Mail Address: \_\_\_\_\_

*TAKE a tip from us...*

MO YALE DENTAL  
 5 East Main Street  
 Clinton CT 06413  
 1-800-246-YALE  
 Fax: 203-773-9832  
[www.moyaledental.com](http://www.moyaledental.com)  
[moyaledentalinc@yahoo.com](mailto:moyaledentalinc@yahoo.com)

Have instruments been sterilized? Y or N

<u>Qty</u>	<u>Same Tip as # on Handle</u>	<u>S/E</u>	<u>D/E</u>	<u>If want Tip changed, change to a:</u>	<u>Cost</u>

If an instrument is not retippable, we will send a new stainless steel one for only \$17.49!

Less 10% discount for Referral\*\* \_\_\_\_\_  
 Plus Shipping and Handling \_\_\_\_\_  
 (s&h: 0-60 instr. \$10.25; 61-80 \$12.25; 81-100 \$14.25;  
 >100 call for quote )

**Total Due:**

\*\*Referral Program: Receive 10% off this order simply by referring MO Yale to another Dentist

**WHO ARE YOU REFERRING?**

Referred DDS Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ City, State: \_\_\_\_\_

Please make checks payable to " MO Yale Dental".

We also accept Visa, MC and Amex. CC#: \_\_\_\_\_ Exp Date: \_\_\_\_\_

**ULTRASONIC INSERT ORDER FORM**

INSERT REPAIR (please specify 25k or 30k)

Tip required:

_____ P-100 (perio)	_____ P-100k (right perio)	_____ P-50 (standard)
_____ BITS (implant scaler)	_____ P-6 (beaver tail)	_____ 13/14
_____ P-100L (left perio)	_____ P-1 (cement remover)	_____ other

TOTAL # of INSERTS: \_\_\_\_\_

Titanium Implant Sealer (TIS) \_\_\_\_\_

New Insert: Specify quantity and tips required \_\_\_\_\_