LOGIC TECH CORP

Dedicated to merging technology and dentistry through innovative solutions.

Paradigm V6

Charting Manual

to learn more follow us on

Logic Tech Corp, 620 Alden Road, Unit 106 - Markham, ON L3R 9R7
T. 905-946-1477 - F. 905-940-9893
1-800-655-5762
info@logictechcorp.com **www.logictechcorp.com**

Paradigm V6:

Charting User Manual

In order to highlight interesting or important features within this manual, two types of text boxes are used throughout.

Quick Tip text boxes offer notable points in how you can interact with the Paradigm software.

Please Note text boxes provide vital information that **may** affect the functionality of the Paradigm program.

Ensure that you read and follow the information in these boxes.

Note that all figures and diagrams appear on odd-numbered pages.

Contents

About Logic Tech Corp.

Logic Tech Corp. is a Canadian company that has been servicing the dental industry proudly for more than 25 years. Our software continues to be a leader in the evolution of practice management solutions.

At Logic Tech we are dedicated to merging new technologies with our Paradigm software to provide dental offices with the very best product on the market. Our software has evolved through many versions to accommodate the changes in the dental industry over the decades. Whether it's through sending electronic insurance claims or helping to digitize patient records, we strive to service all dental office needs. The speed of technology continues to change the landscape of our society and we look to embrace those new technologies and incorporate them with our Paradigm software.

Whether the dental office is a single provider or a large clinic with dozens of providers, our software can handle your needs. Our expandable modules enable offices to customize our Paradigm software to their specific needs.

Disclaimer

Logic Tech Corp. is not responsible for any data loss or misconfiguration incurred while using this manual. We also reserve the right to revise and make changes to the content of this publication without notice.

Copyright

Perio Charting 1

Perio Charting Module

PERIO CHARTING INTRO

Perio Charting tracks patients' perio conditions. The perio charting module allows paperless recording of pocket measurements and comparing measurements from previous patient examinations. The period module also allows the user to track bleeding, gingivitis, and other conditions easily.

Opening Perio Charting

To use **Perio Charting**, first select your patient by clicking on an appointment, or by performing a patient search. Once the patient is selected, click on the **Perio Charting** button located on the upper right-hand side of the Paradigm toolbar (**Figure 1.1**). The *Perio Chart* program will open, presenting a blank perio screen (**Figure 1.2**).

OVERVIEW OF THE PERIO CHARTING SCREEN

Please see **Figure 1.3** on page 11. There are three main areas inside the *Perio Charting* module:

1 Menu Bar

When the **Perio Charting** module first opened, not all of the buttons will be visible (**Figure 1.2**). Once a new examination for the patient is created, the rest of the buttons in the **Perio Charting** module will be visible (**Figure 1.3**). The buttons in this area are as follows:

- **File**: This button is used to save a current exam that has not been closed. When more than one exam has been entered, it will be possible to compare these exams by clicking on **Previous Exam./Compare.**
- **Setup**: Sets the direction in which the perio conditions are entered. Depending on the version of Paradigm V6, a left-to-right direction may only be available.
- This button sends the current perio exam to the printer.

Quick Tip

Be careful when accessing the **File** tab. Once an exam is **closed,** it is no longer possible to add or modify within that particular exam.

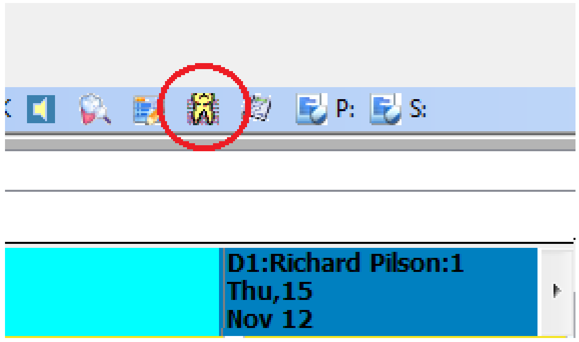


Figure 1.1

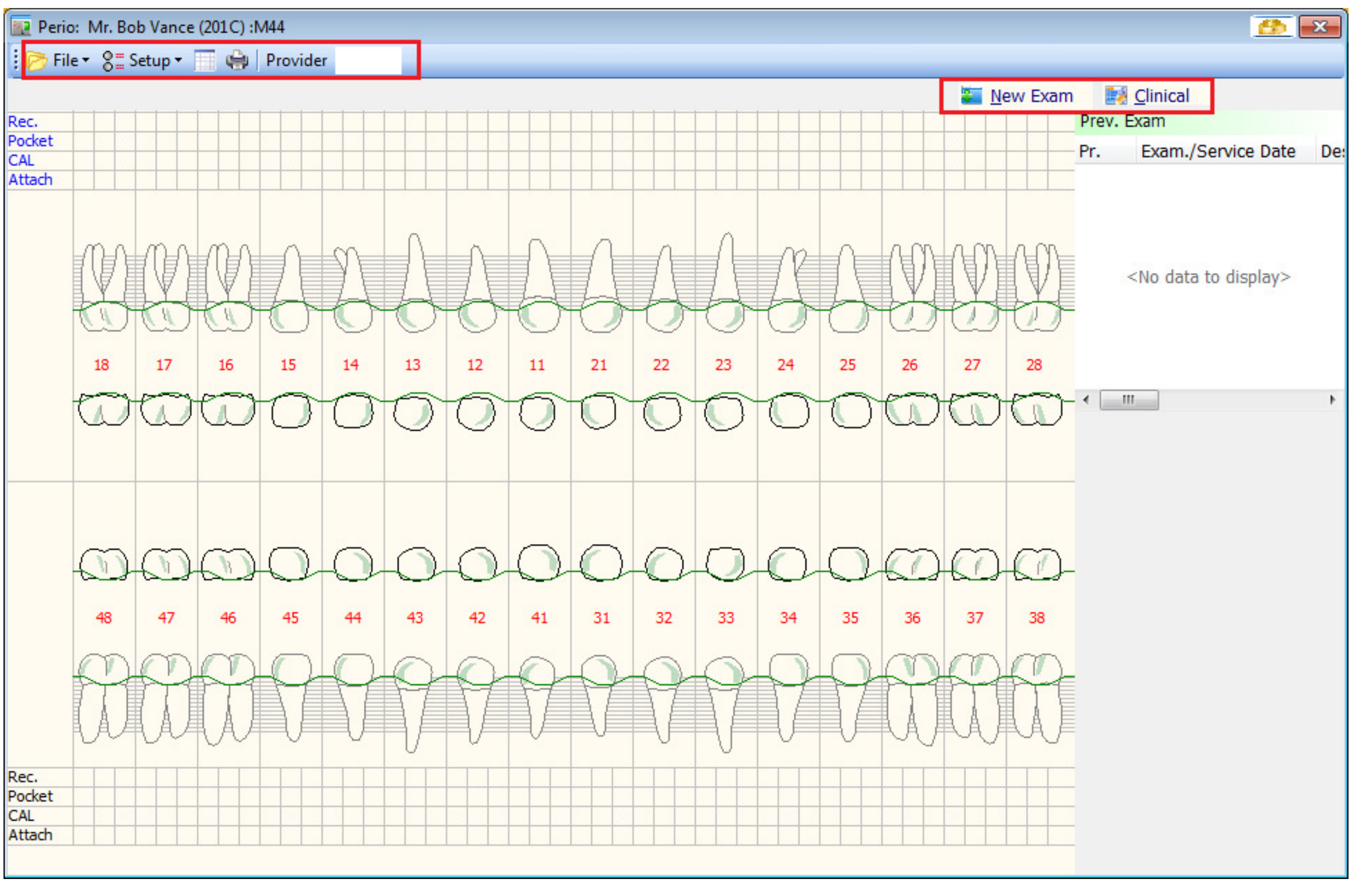


Figure 1.2

- **Provider**: Shows which provider has performed the perio exam. The provider information corresponds to the provider the patient's appointment is booked under. A different provider may be specified.

- **Bleeding, Delayed Bleeding, Suppuration**: Inserts a bleeding, delayed bleeding, or suppuration icon in a patient's chart.
- Recession Pocket Attached Gingiva Mobility Furcation These buttons enable the entry of specific tooth/gum conditions.

- **New Exam**: opens a new exam

- **Clinical**: opens the **Clinical Notes** module

2 Exam Note/Tooth Number Area

Your current selected tooth in the **Perio Charting** module is shown here. The *Exam Note* box contains the name of the examination and any notes you have added to it. Once an exam is created, two more buttons are available for use: **Close Exam**, **Exam Note**, and **Delete Exam**. The bottom of the screen lists any previous examinations this patient has had.

3 Perio Charting Exam Area

This area is to enter, modify, or delete perio conditions for each patient (**Figure 1.4**). There are five areas of importance in this section:

Section A: Displays the different perio conditions for the patients' teeth/gums. Perio conditions such as *Bleeding*, *Recession*, *Pocket*, and *Attached Gingiva* can be specified in this area.

Section B: Refers to the *Upper Facial* or *Lower Lingual* areas of the patients' teeth (Bleeding, Suppuration, Furcation conditions appear here).

Section C: Refers to the *Upper Lingual* and *Lower Facial* areas of the patients' teeth (Bleeding, Suppuration, Furcation conditions appear here).

ENTERING PERIO CONDITIONS

In order to enter perio conditions for a patient, you must first create a new exam. Click on the **New Exam** button in the upper right area of the **Perio** module (**Figure 1.1**). An *Examination Note* box will appear. Enter a name for this exam and any relevant notes. Click on the **Save** button. The box will close, and the chart is ready to enter perio conditions. To enter a **bleeding**, **delayed bleeding**, or **suppuration** condition, left-click on the appropriate icon on the top of the *Menu Bar*, and then within the *Perio Charting Exam Area* left click on the appropriate surfaces to enter the bleeding conditions (**Figure 1.5**, page 13).

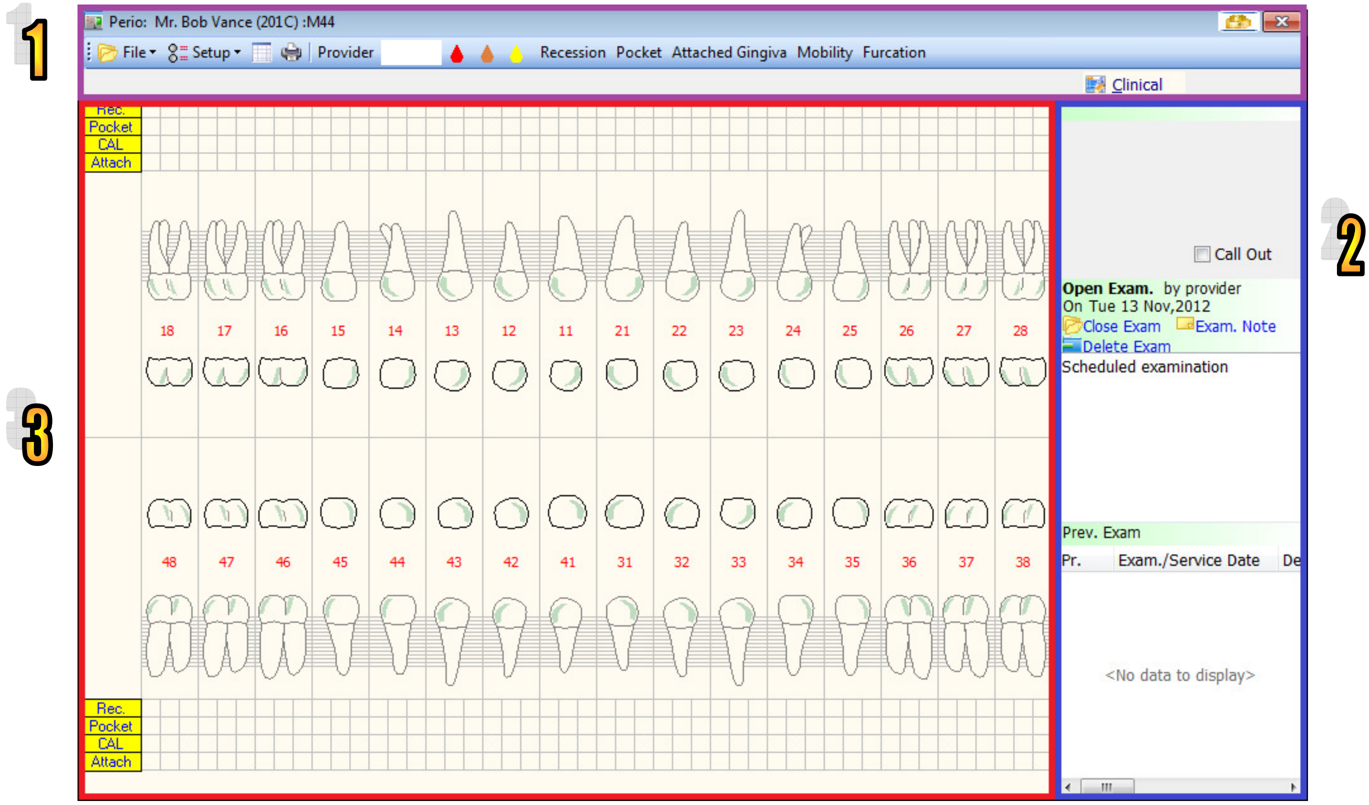
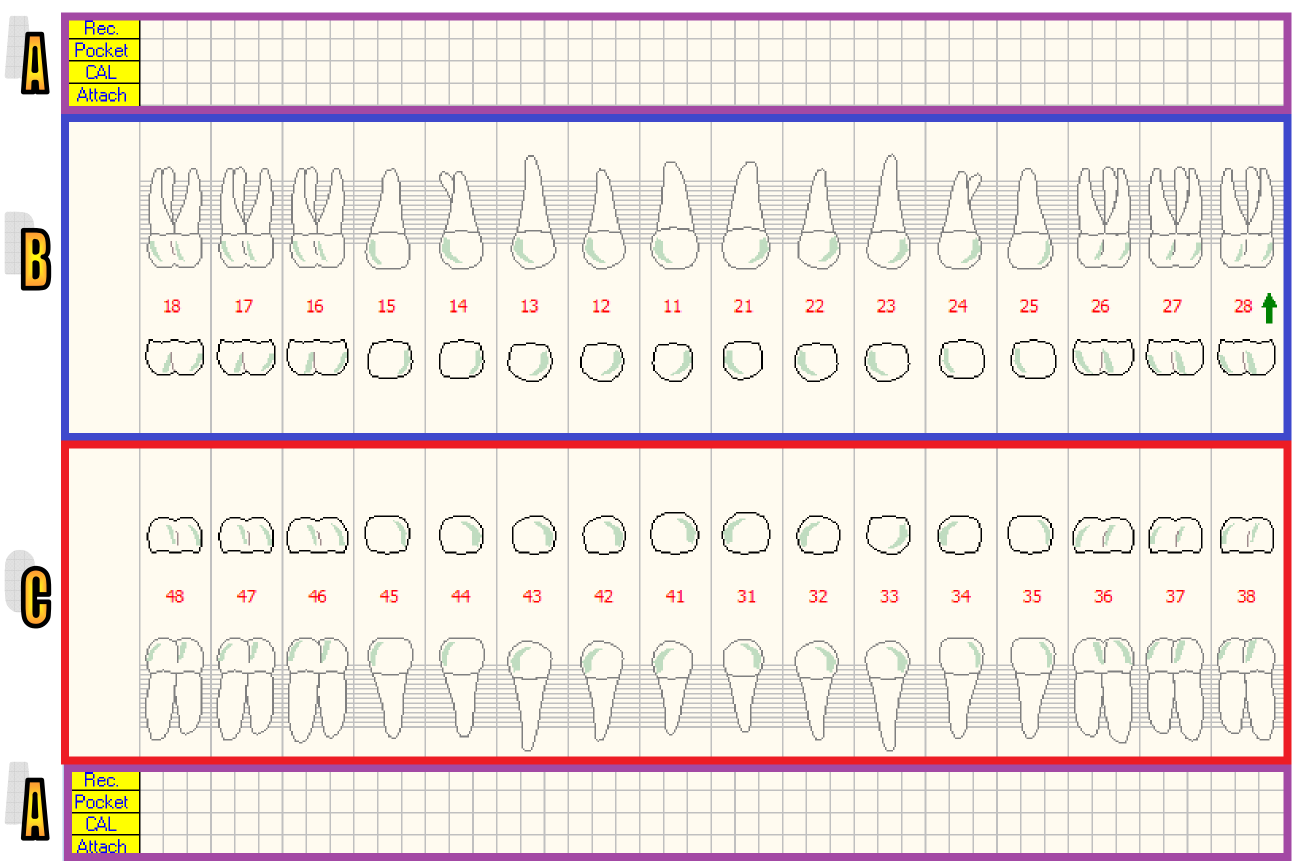


Figure 1.3



The Pointer arrow designates which tooth and surface is currently selected in the perio chart.

Figure 1.4

Quick Tip

Left-click to place the green arrow in the desired location, select which condition to enter, and then use the number bar at the top of the charting area to enter your patient's condition level.

Quick Tip

To remove an incorrectly entered bleeding or suppuration condition, select the appropriate icon on the *Menu Bar*, and left-click on the desired entry in the charting area—the entry will disappear.

Ensure to have the correct condition selected—otherwise, instead of removing the invalid condition, another one may be entered.

To enter *Recession, Pocket*, *Attached Gingiva*, *Mobility*, or *Furcation* conditions, left-click on the appropriate button on the top-right of the **Menu Bar**. The name of the selected condition also appears in the **Exam Note/Tooth Number** area. The number bar for the specified condition also appears at the top of the **Perio Charting Exam Area** (Figure 1.5). Ensure that the *green arrow* is at the desired data entry location. Perio exam conditions are only added to the *green arrow* location.

Use the number bar at the top of the exam window to enter the proper condition levels (Figure 1.6). Note that clicking on the numbers moves the *green arrow* across the chart. After entering the conditions on the top row (facial surface), it will continue on the bottom row (lingual surface). You may also use the number keys on the top row of your keyboard to enter the conditions levels.

Modifying an Exam Note

When first creating a new perio exam an **Exam Note** can be entered. This note is only for this specific exam—it is not stored or viewed anywhere else. Modifying or adding additional information to an exam note is possible by clicking on the **Exam Note** button. Once finished with the note, click on the **Save** button (Figure 1.7).

Saving and Closing an Exam

If you need to close the perio charting window but want to keep the examination open to continue adding conditions later, click on the **File** button on the top left of the *Perio Charting* screen and click **Save** (Figure 1.8). This will give you the option to return to the **Perio Charting** and continue where you left off.

Note that only one perio exam can be open at a time per patient. To start another perio exam the current exam must be closed. To close a perio exam click on the **Close Exam** button (Figure 1.9).

In the next dialog box, click on the **OK** button to close the exam. Be aware that once the exam is closed changes can no longer be made to that exam, and incorrect entries cannot be removed. Ensure all the information in the perio chart is correct before closing the exam. Once the exam is closed, a new exam can be added into the system.

Viewing Past Perio Exams

In the **Exam Note/Tooth Number** area, all of this patient's previous exams are located in the **Prev. Exam** box. You can view the previous exam by double left clicking on the entry. Examinations can be compared if the patient has more than one previous exam. Click on **File** and then click on **Previous Exam./Compare**. Click on Upper/Lower and Recession/Pocket in order to compare the condition levels for all previous examinations. (Figure 1.10).

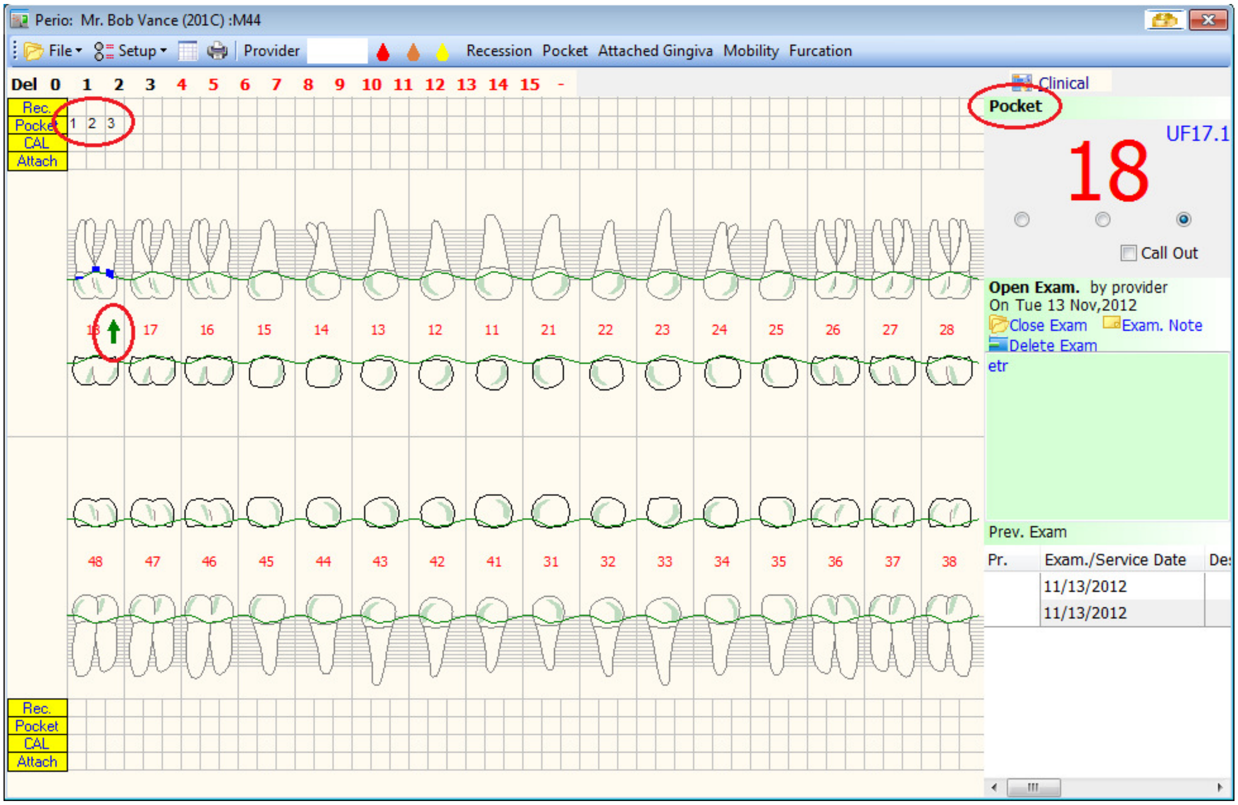


Figure 1.5

Quick Tip

The CAL column stands for **Clinical Attachment Level**, **not** Clinical Attachment Loss.

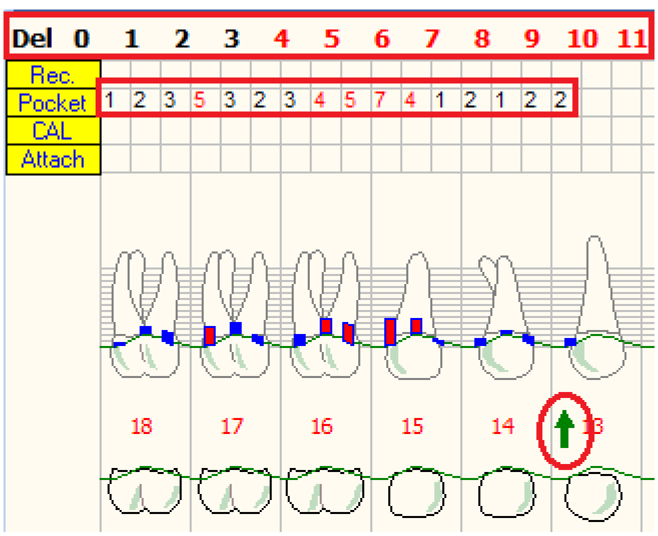


Figure 1.6

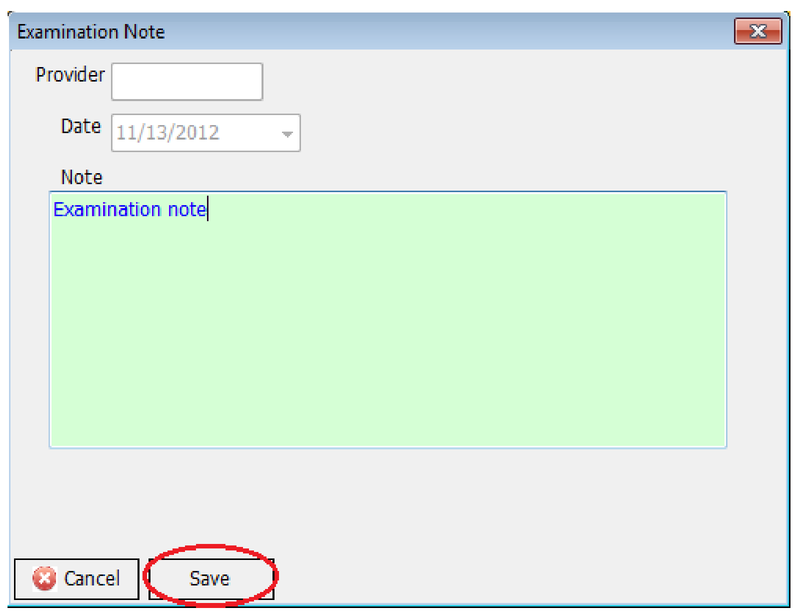


Figure 1.7

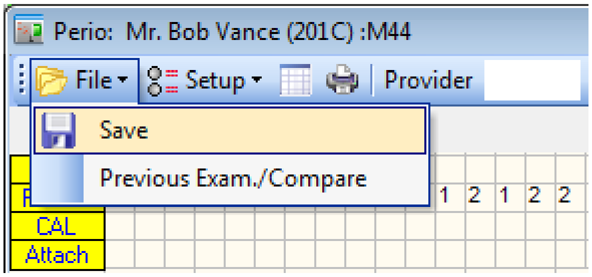


Figure 1.8

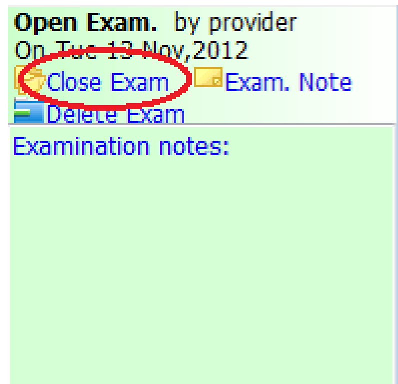


Figure 1.9

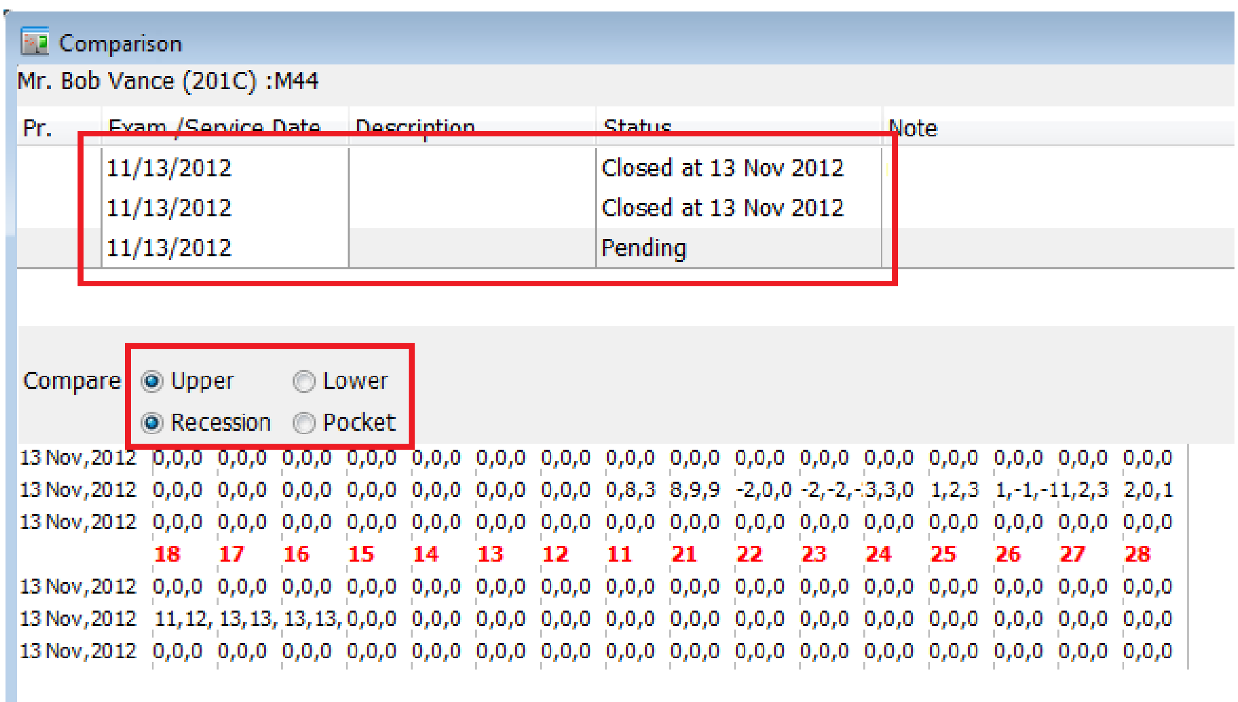


Figure 1.10

Clinical Notes 2

Clinical Notes Module

CLINICAL NOTES OVERVIEW

The **Clinical Notes** module is designed to give optimum flexibility and ease of use. You can store your clinical notes in digital form, create examination note templates, and create custom examinations for your patients.

After saving the notes/exams, they become a permanant part of the patient's record. Furthermore, **Clinical Notes** are easily retrievable for reference and additional note entry.

Opening Clinical Notes

To use **Clinical Notes**, first select a desired patient through their appointment, or by performing a patient search. With the name showing at the top left of the Paradigm V6 window, click on the **Clinical Notes** button on the right side of the *Menu Bar* (Figure 2.1).

OVERVIEW OF THE CLINICAL NOTES SCREEN

There are five sections within **Clinical Notes** (Figure 2.2).

1 Patient Name

Displays the selected patient account in which the clinical note is stored.

2 Menu Bar

Save: Saves any work entered in *Clinical Notes*.

Print: Sends all clinical note entries to a preview screen. From there they can be sent directly to the printer.

Template **Template (insert):** Bring up a list of predefined/user-defined note templates to be inserted into the clinical note.

Clear: Erases any text entered on today's date **only**. This option is unable to erase text from a past date, or text that was **digitally** signed.

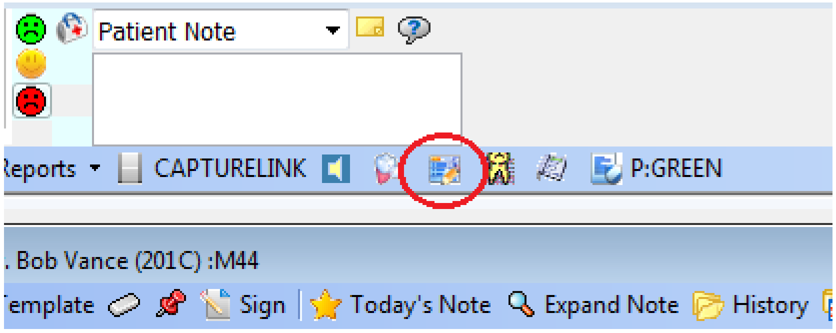


Figure 2.1

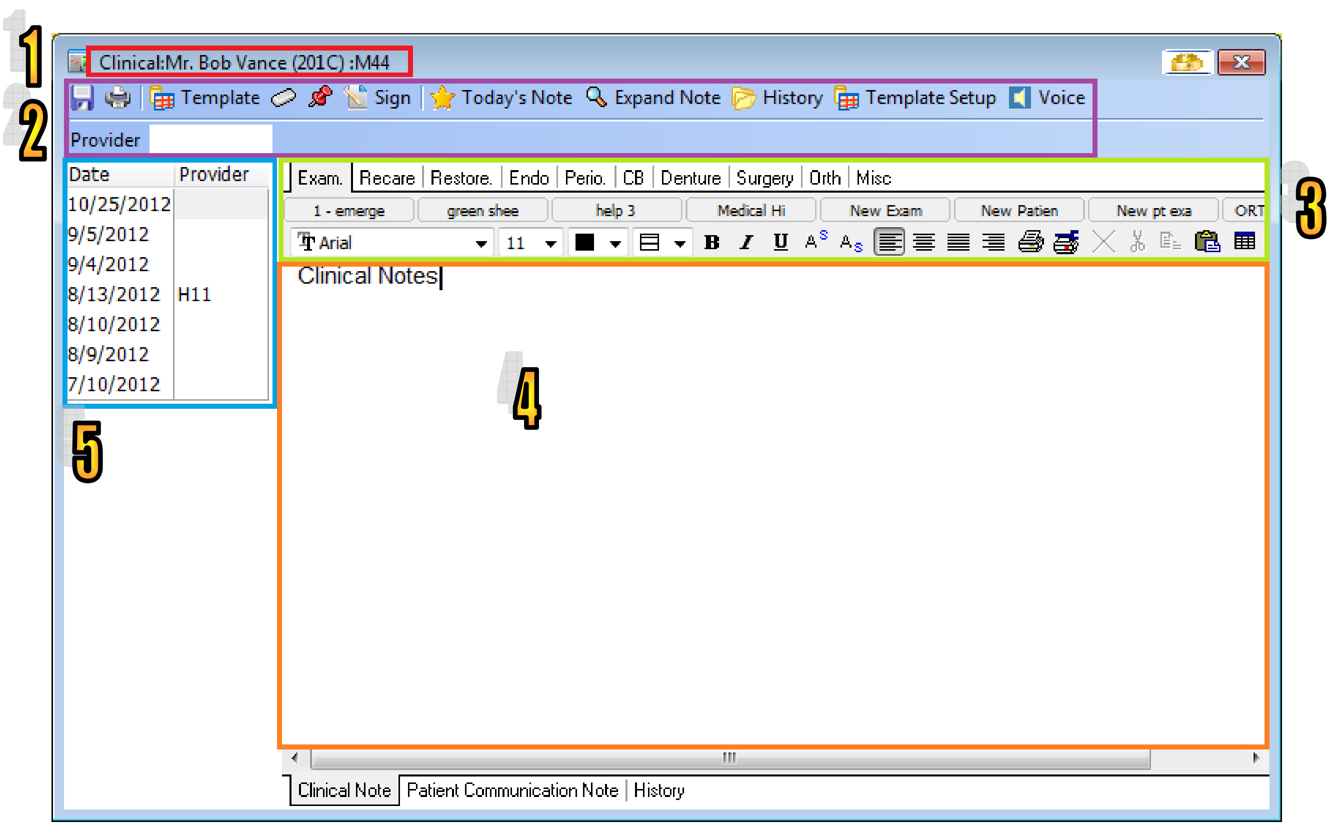


Figure 2.2

Quick Tip

Digital signatures are only applicable for notes that are entered on today's date.

Date Line: Inserts the date, time, and user code of who is logged into the program.

Sign: Once digitally signed, no modifications can be made to a clinical note entry. Note that to digitally sign a clinical note, the *Ink Kit* must be installed.

Today's Note

Today's Note: After viewing any past notes, selecting this button will go back to today's clinical note entry.

Expand Note

Expand Note: Expands the currently selected History note to show in a larger window.

History

History: Toggles the left sidebar that displays the list of past notes (**Figure 2.4**).

Template Setup

Template Setup: Creates user-based clinical note templates.

Provider

Provider: Displays the provider code (e.g. D1) under which a patient has been booked. If the **Provider** box is blank or the code is incorrect, enter the preferred provider code.

Append Today's Treatment

Append Today's Treatment: If any treatments are processed after accessing *Clinical Notes*, this will append the treatment codes to the note.

3 Toolbar

Use the buttons and options in this area to tailor the clinical note entries to your preference (changing the font type, font colour, bolding/underlining, centering the text, etc).

4 Clinical Note Text Entry

Type notes in this area, or use the **Template** button to insert pre-defined/custom templates. When entering new clinical notes for a given day, you can click on the *Red Pin* icon to insert the date and time before typing your note. In addition, any treatments entered **before** accessing *Clinical Notes* will display underneath the *date line*, and any **after** will be available to append (**Figure 2.3**).

Quick Tip

As already mentioned, once a clinical note is relegated to the past, it cannot be changed or modified.

Ensure that all notes are correct before closing the office for the day.

5 Clinical Note History

Any notes entered prior to today's date display in this section. Use the **Append Note** button to add extra information to a past clinical note. **Note** that a clinical note entry cannot be modified or deleted once it is digitally signed, and/or is relegated to the clinical note history. The clinical note history is located on the left side of the **Clinical Notes** window. Double left click on a past day in order to see the notes saved from that day (**Figure 2.4**).

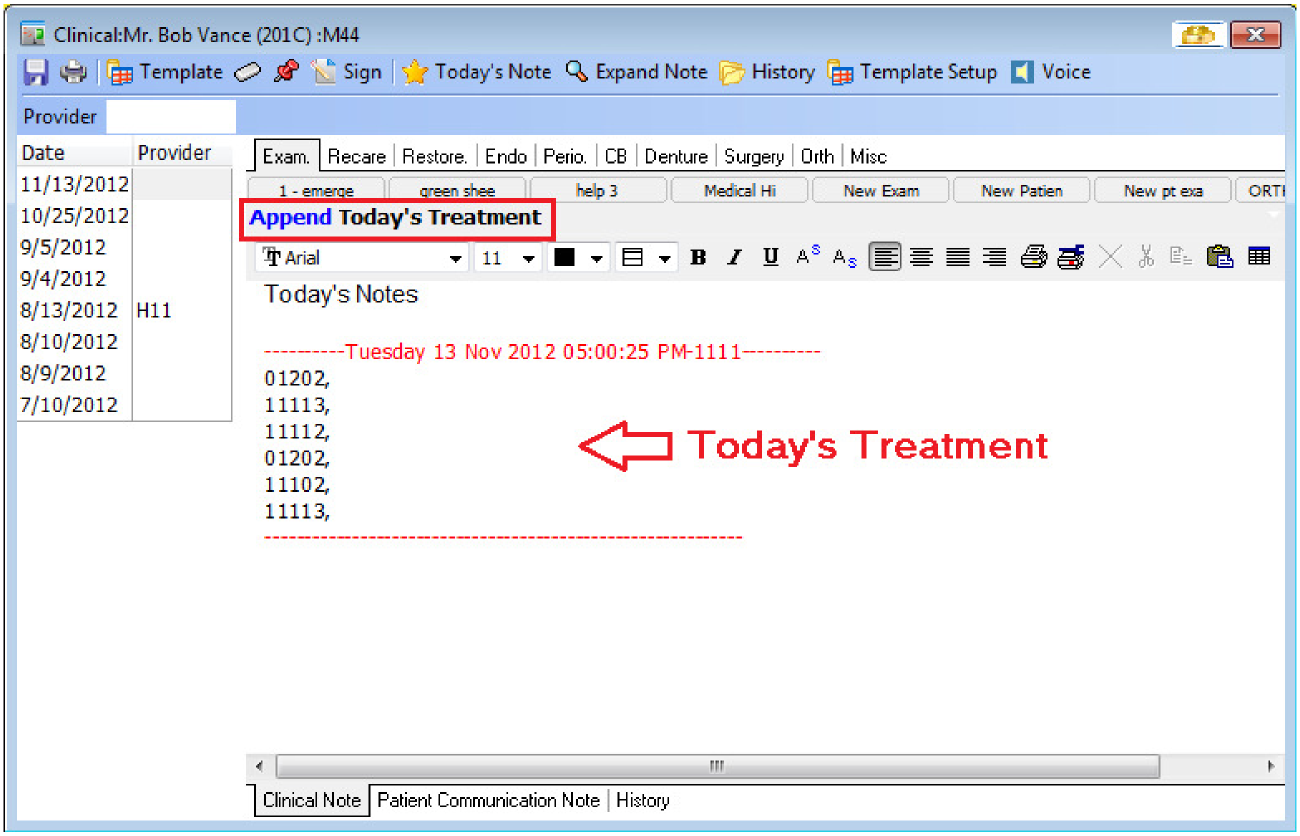


Figure 2.3

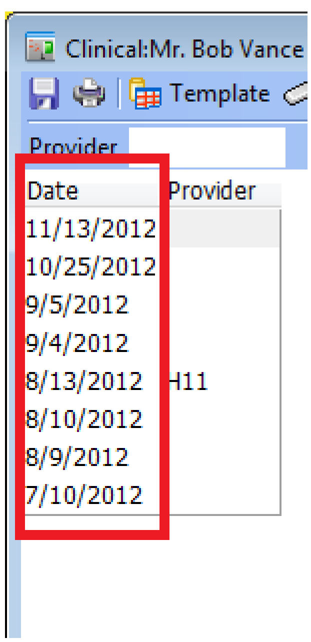


Figure 2.4

ENTERING CLINICAL NOTES

Quick Tip

To not have the date stamp line appear in a clinical note, simply highlight and delete it.

Custom Notes

To manually enter a note (not from a *Clinical Notes* template), left-click within the *Clinical Note Text Entry* box and begin typing the note. Clicking on the **Save** button will save the note. Closing the clinical note window without saving will cause the note to disappear. The Date and time can be appended to the note by clicking on the *Red Pin* icon located above the toolbar.

Please Note!

Closing the ***Clinical Notes*** window without saving the note will cause all changes to be lost.

Be sure to save your notes before closing!!!

Previously Entered Treatments

Any treatments processed today can be added to the patient's *Clinical Notes.* Treatments that can be added include those entered from **Billing** and also those entered in the **Restorative Charting** module.

To add today's treatments to the *Clinical Notes*, click on **Append Today's Treatment** located above the **Toolbar** in the *Clinical Notes* module. It will add today's date stamp in red and also all of today's treatments.

CUSTOM TEMPLATES

Quick Tip

If you access *Clinical Notes* and **then** process a treatment, the treatment codes will not display within the *Text Entry* box.

You will have close and reopen *Clinical Notes* to see the treatments.

Creating custom templates can aid in tracking the overall oral health of the patients. In Paradigm, there may be predefined templates from which to choose. Custom templates are easy to create, modify, use, and remove.

To create a custom template, click on the **Template Setup** button on the top right of the clinical note window. Choose the **Create New Template** option (**Figure 2.5**). Type in the name of the template being created, and then click on the **Finish** button.

The *Clinical Note Template* screen will open. First left-click on the name of the created template under the *Exam Type* column, then left-click on the **Add** button under the *Template Details* (**Figure 2.6**). The *Template Details* box contains all of the examination questions that you have added to your template.

Quick Tip

When creating a template, note that although there is no standard limit to the number of examinations one can enter, do not enter so many examinations that the clinical notes become hard to read.

In the bottom part of the *Clinical Note Template* screen (**Figure 2.6**), type in the name of the examination question in the *Examination* field. Now choose the format in which to present the examination question. There are three different format types, accessible by clicking on the drop-down arrow next to the *Data Type* field:

- **Text**: Select this option to create a text box in which test can be entered. Ex. The text box can be used for entering a provider name or for entering required medication for the patient.

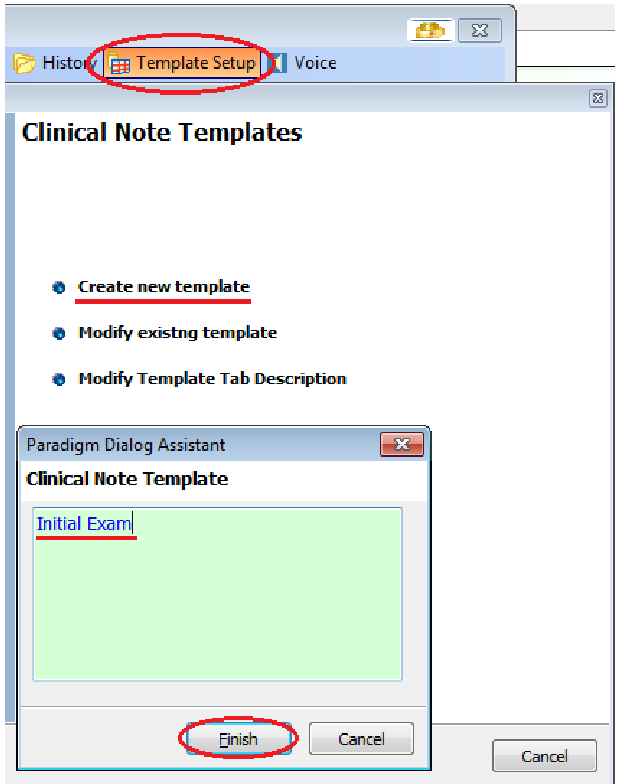


Figure 2.5

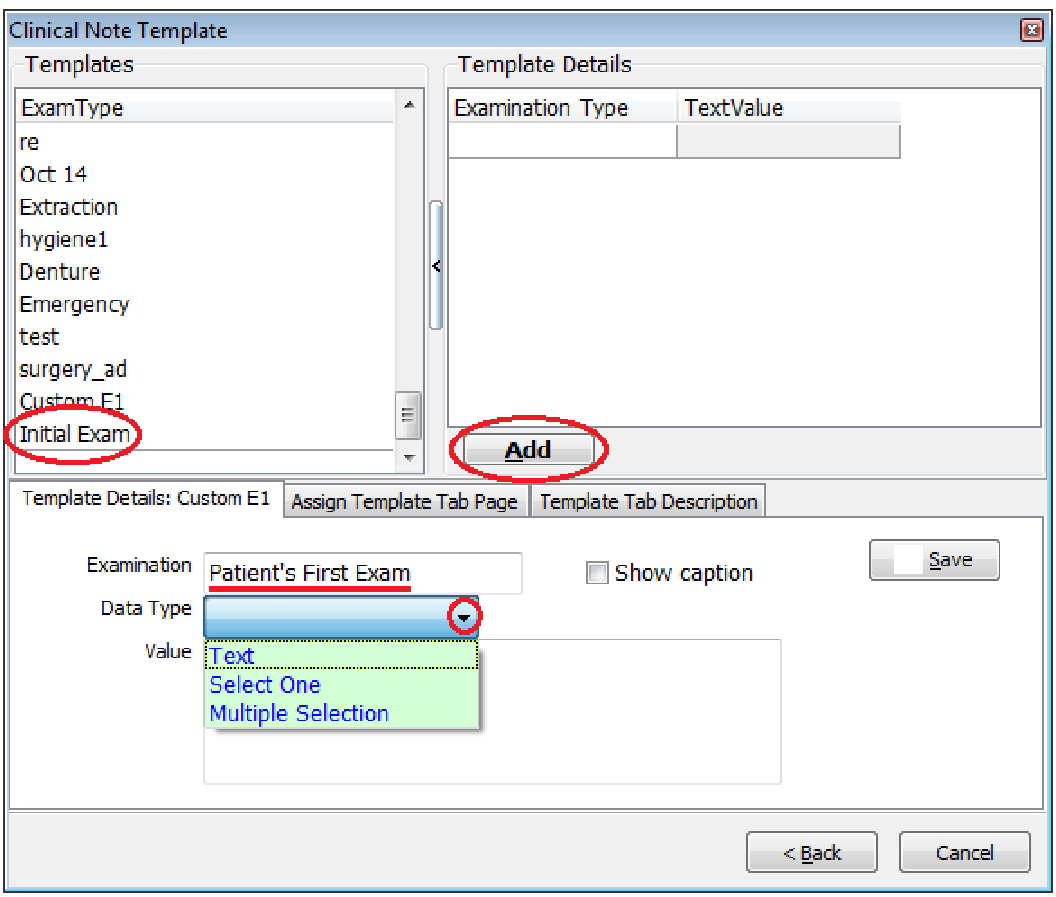


Figure 2.6

- **Select One**: Creates up to nine options, where only **one** option may be selected at one time. It can be used to classify overall oral health: ex. **Good**, **Fair**, **Poor** (**Figure 2.7**). Once this option is chosen, enter in the appropriate options in the *Value* fields.
- **Multiple Selection**: Creates up to nine options (checkboxes) where any number of options can be selected at one time (such as listing different health factors for a patient's teeth. **Figure 2.8**). Once **Multiple Selection** is selected from the drop-down box, enter the category information for each of the checkboxes that are required.

After entering each *Examination* name and examination option, be sure to click on the **Save** button, otherwise the examinations will not save. To add more than one examination, click on the **Add** button, and then repeat the process of entering an *Examination* name, *Data Type*, then *Value(s).*

Upon completion of this process, the new Exam entries will appear on the right-hand side of the *Clinical Note Template* screen, under the *Template* Details column (**Figure 2.9**).

Quick Tip

At this point, templates can be assigned to the quick tabs seen across the top of the clinical note window. To do so, modify the template and select the desired tab category under *Assign Template Tab Page*, then **Save**.

Inputting Templates

To enter templates into a patient's clinical notes, click on the **Template** button on the top-left of the Menu Bar. The *Select Template* box will open (**Figure 2.10**). Find the desired template and double-click on it.

Within the *Apply Template* box enter in the required information, and then click on the **Apply** button on the bottom left-hand side (**Figure 2.11**). The information applied will now appear in the *Text Entry* area. Remember to click on the **Save** button to save this note!

BROWSING PAST CLINICAL NOTES

To view past clinical notes, select the desired note from a previous day on the left sidebar to bring up the note for that date (**Figure 2.12**). If the *History* sidebar is not visible, then click on the *History* button History to enable the *History* sidebar.

APPEND NOTE

Quick Tip

You cannot add in templates when using the **append note** function. Can only add in text.

Remember that any note that is relegated to the past cannot be modifed or deleted. It is possible, however, to append to a note that is in the clinical note history. To do so, select the desired *History* note on the left sidebar to bring up the note for that date (**Figure 2.12**).

Click on the **Append** button, as shown in **Figure 2.12**. Type the necessary information in the *Append Clinical Note* box, and then click on the **Finish** button (**Figure 2.13**). Please note that it is not required to click on the Save button when adding an appended note. It will save automatically, however the *Clinical Notes* need to close and reopen to see the appended note.

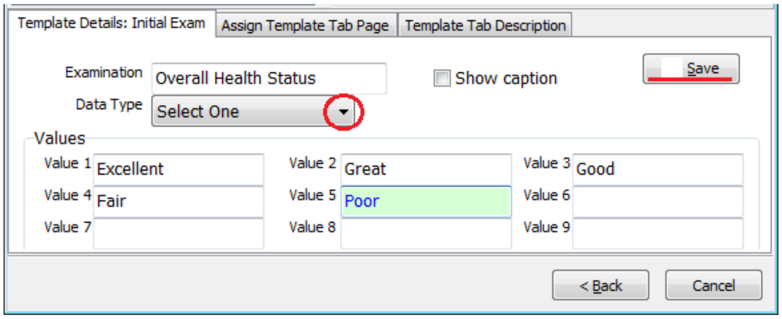


Figure 2.7

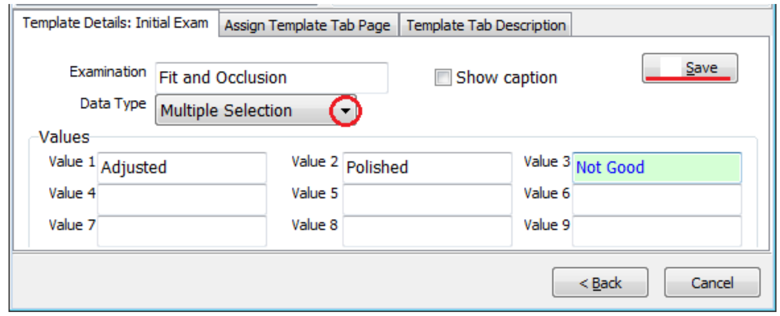


Figure 2.8

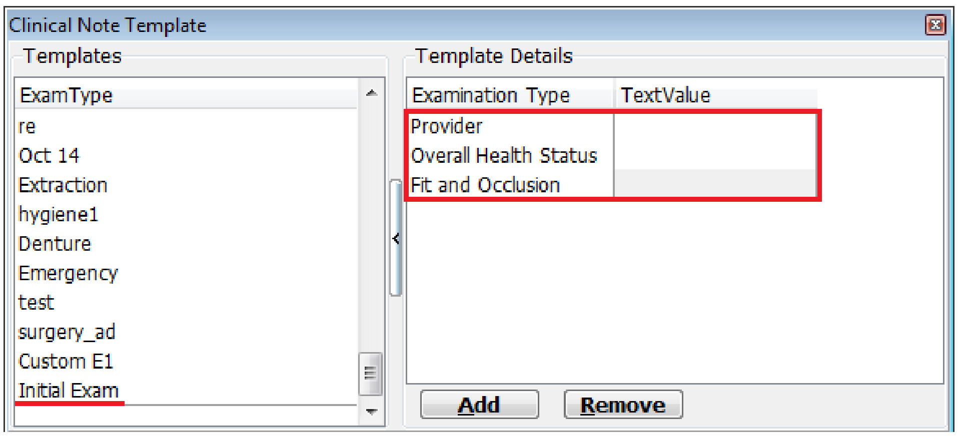


Figure 2.9

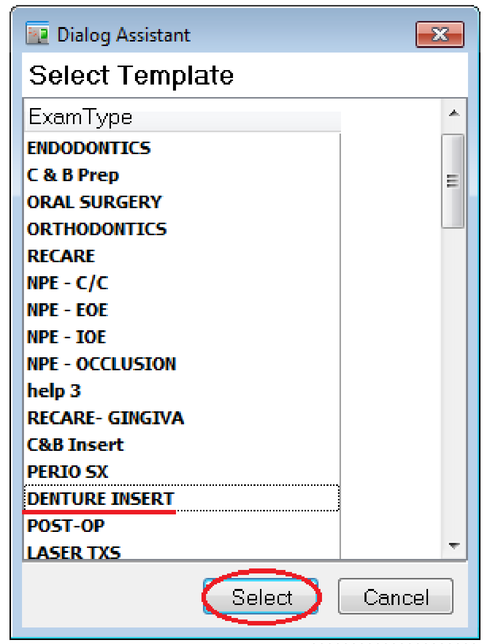


Figure 2.10

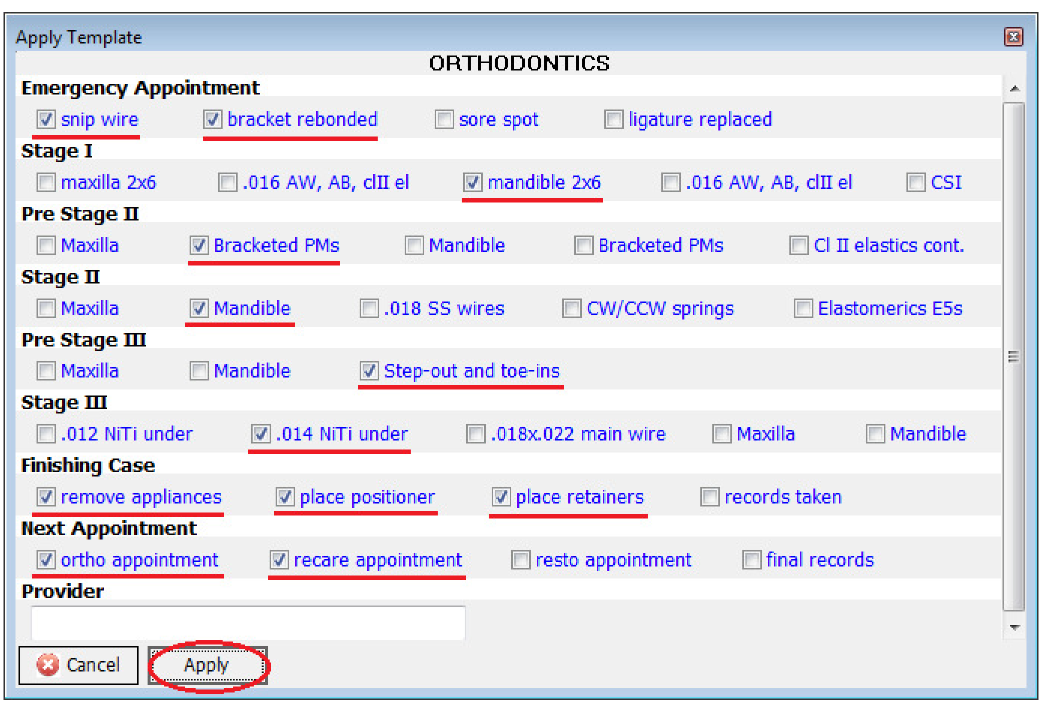


Figure 2.11

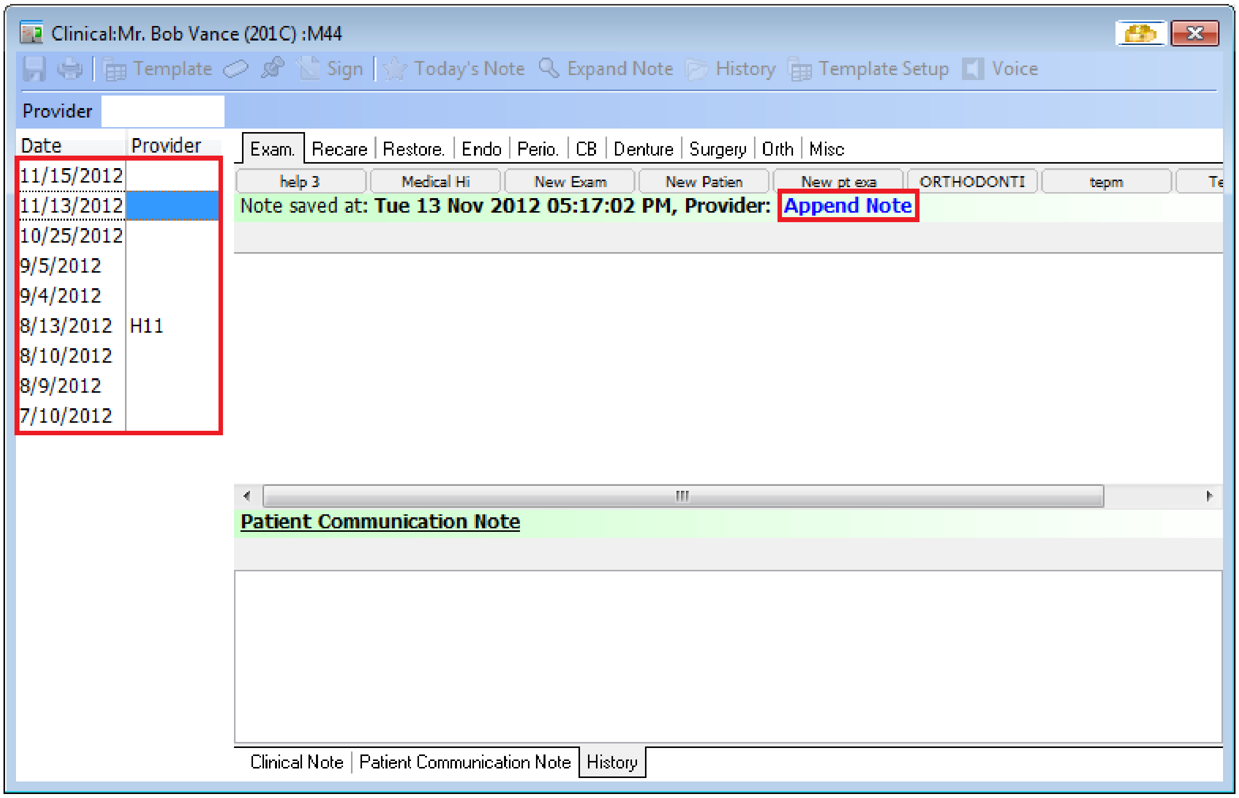


Figure 2.12

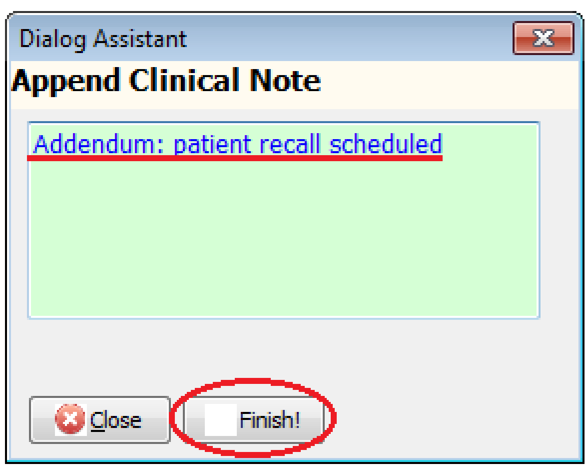


Figure 2.13

PRINTING CLINICAL NOTES

Quick Tip

Selecting a past note from the left sidebar will only bring up a quick view of that note in the *History* tab. For a full printable view click on **Expand Note**, then select the note from within that window.

To print today's clinical notes, click on the **Print** icon located on the top left-hand side of the Menu Bar (Figure 2.14). Select the desired printer and then click on the **OK** button to print the patient's clinical notes.

Printing Past Clinical Notes

To print a clinical note from a previous day, click on the **Expand Note** button in the *Menu Bar* and select the note from the list of previous notes on the left side. From here the clinical note can be printed by using the **Print** button located in the upper right corner of this window (Figure 2.15).

DELETING CLINICAL NOTE TEMPLATES

When *Clinical Note* templates are no longer needed for patient examinations, they can be removed from the template database. To remove any templates, perform the following steps:

1. Click on the **Template Setup** button (located on the top-right hand side of the Menu Bar), and then select **Modify existing template**.
2. Left click on the template to be deleted (Figure 2.16).
3. Press the **Delete** button on your keyboard and click **Yes** on the dialog box to delete the template (Figure 2.16).

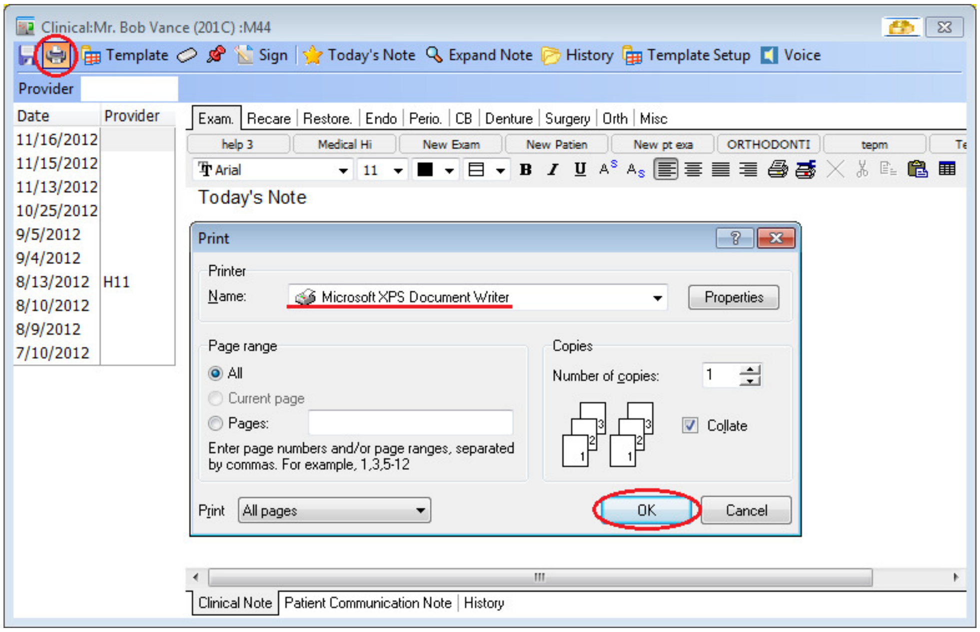


Figure 2.14

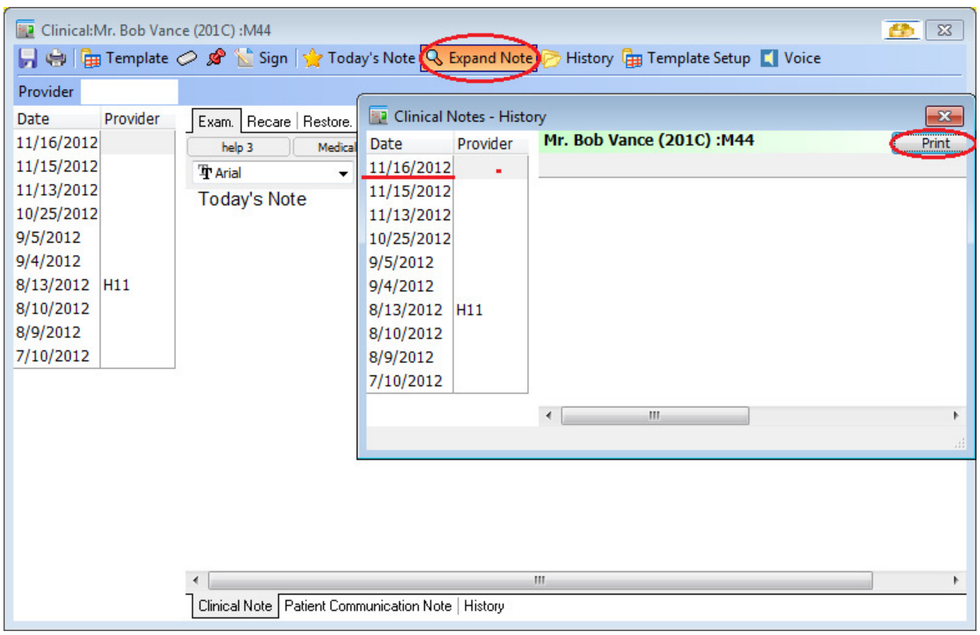


Figure 2.15

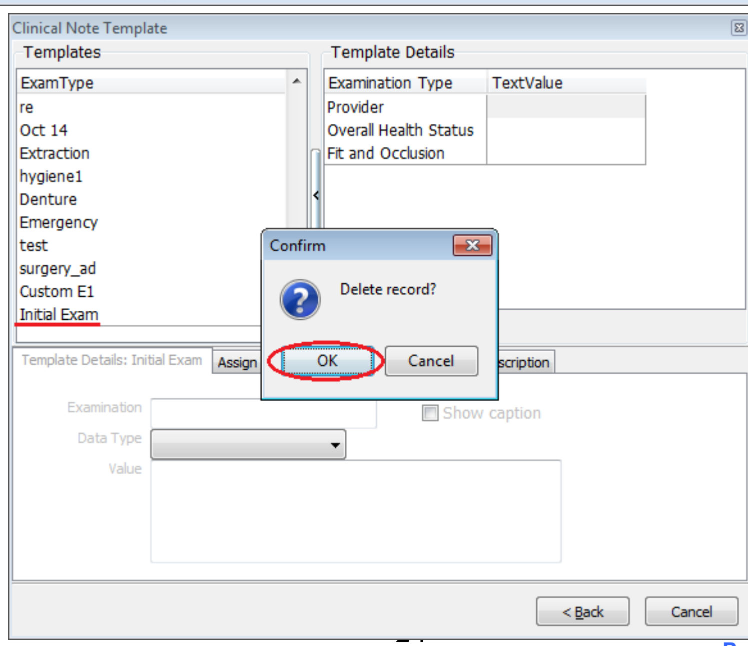


Figure 2.16

QUICK TABS

Located just under the *Toolbar* are ten tabs that allow quicker access to custom templates (**Figure 2.17**). Assign and store different templates under any specific *Quick Tab* category in order to gain access to them quickly.

Paradigm V6 has predefined charting templates under the *Quick Tabs* by default. It is therefore possible to design an original template or modify an existing template by following the guide on page 18: **Custom Templates**.

Modifying Quick Tab Names

Quick Tabs have predefined names that can be changed. To change *Quick Tab* names, click on the **Template Setup** button on the *Toolbar*, and then click on **Modify Template Tab Description**. The *Clinical Note Template* screen will open, and the *Quick Tab* descriptions are on the bottom of this screen (**Figure 2.18**).

Make any desired changes, and then click on the **Save** button. Click on the **Cancel** button to close this screen. Close and reopen **Clinical Notes** for the changes to take effect.

Reassigning Templates within Quick Tabs

As shown in **Figure 2.18**, charting templates appear under specific *Quick Tabs*. To reassign a template to a different tab, click on the **Template Setup** button on the *Toolbar*, and then click on **Modify Template Tab Description**. The *Clinical Note Template* screen will open. First select the template you wish to assign. Then select the *Assign Template Tab Page* tab (**Figure 2.19**).

On the *Assign Template Tab* page, note that there is a number that appears in the *Tab Page* scroll box. This number refers to which (if applicable) *Quick Tab* the template is currently assigned (click on the *Template Tab Description* to see a description of the *Tab*). If the template is not currently assigned to any *Quick Tabs* then the *Tab Page* box will have a value of zero.

To place a template under a different *Tab*, change the number to the corresponding *Tab #* found in *Template Tab Description*. Click on the **Save** button, and then click on **Cancel** to close the screen. Then close and reopen **Clinical Notes** for the changes to take effect.

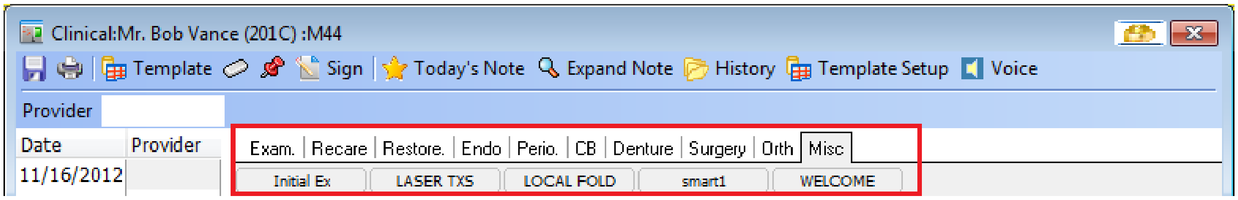


Figure 2.17

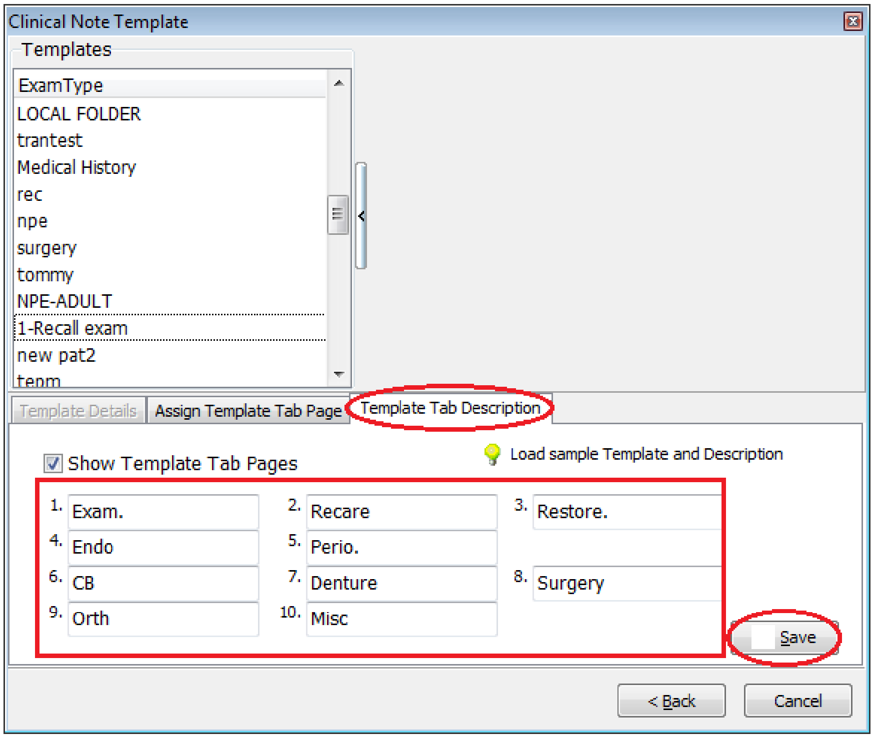


Figure 2.18

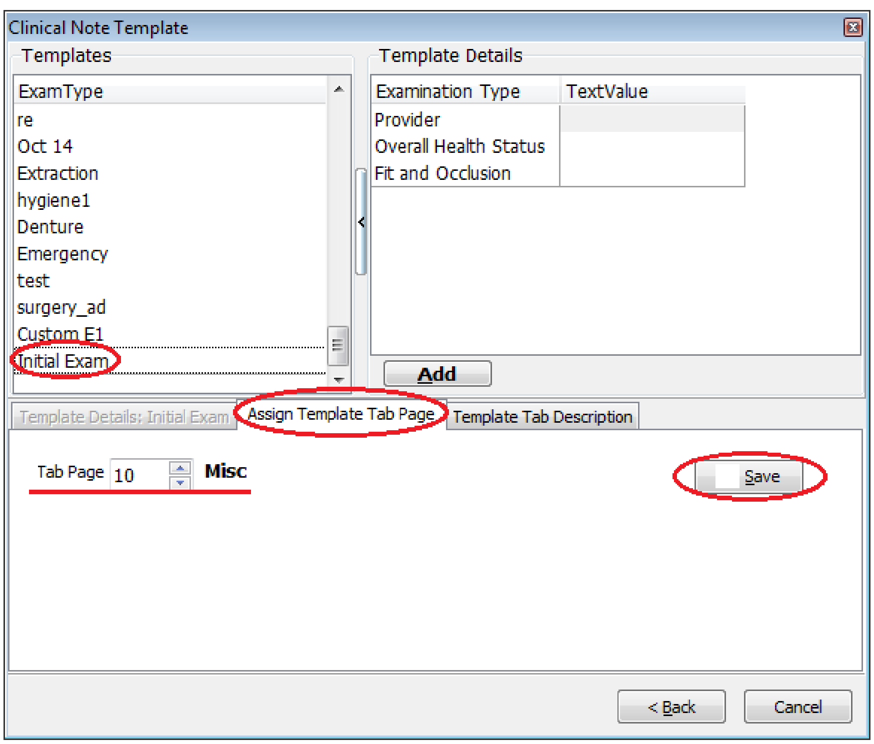


Figure 2.19

Restorative Charting 3

Clinical Notes Module

RESTORATIVE CHARTING OVERVIEW

Restorative Charting makes it simple to track patients' treatments, as well as chart a new patient's existing treatments. It can record fillings, resins, inlays, surfaces, crowns, bridges, etc, all with easy to identify icons.

Furthermore, treatments entered in **Restorative Charting** are automatically posted to a patient's ledger, and vice versa. Enter a treatment in a patient's ledger and it will appear in the *Charting* screen.

Opening Restorative Charting

To use **Restorative Charting** first select a patient, and then click on the **Restorative Charting** icon located on the upper right-hand side of the Paradigm toolbar (**Figure 3.1**). **Figure 3.2** shows the basic area of this screen.

OVERVIEW OF THE RESTORATIVE CHARTING SCREEN

1 Menu Bar

- **Save**: Use this button to post all completed entries or pending entries to a patient's ledger.
- **Perm/Prim**: Switch from a patient's Primary teeth to Permanent teeth all at once (or vice versa), or by selecting individual teeth.
- **Provider**; **Bill to Dr**; **Fee Guide**: This box shows who the service and billing providers are, and which fee guide is being used to bill the treatment.

2 Charting Area

- The Chart area is where the patient's tooth information/conditions/treatments display.

Figure 3.1

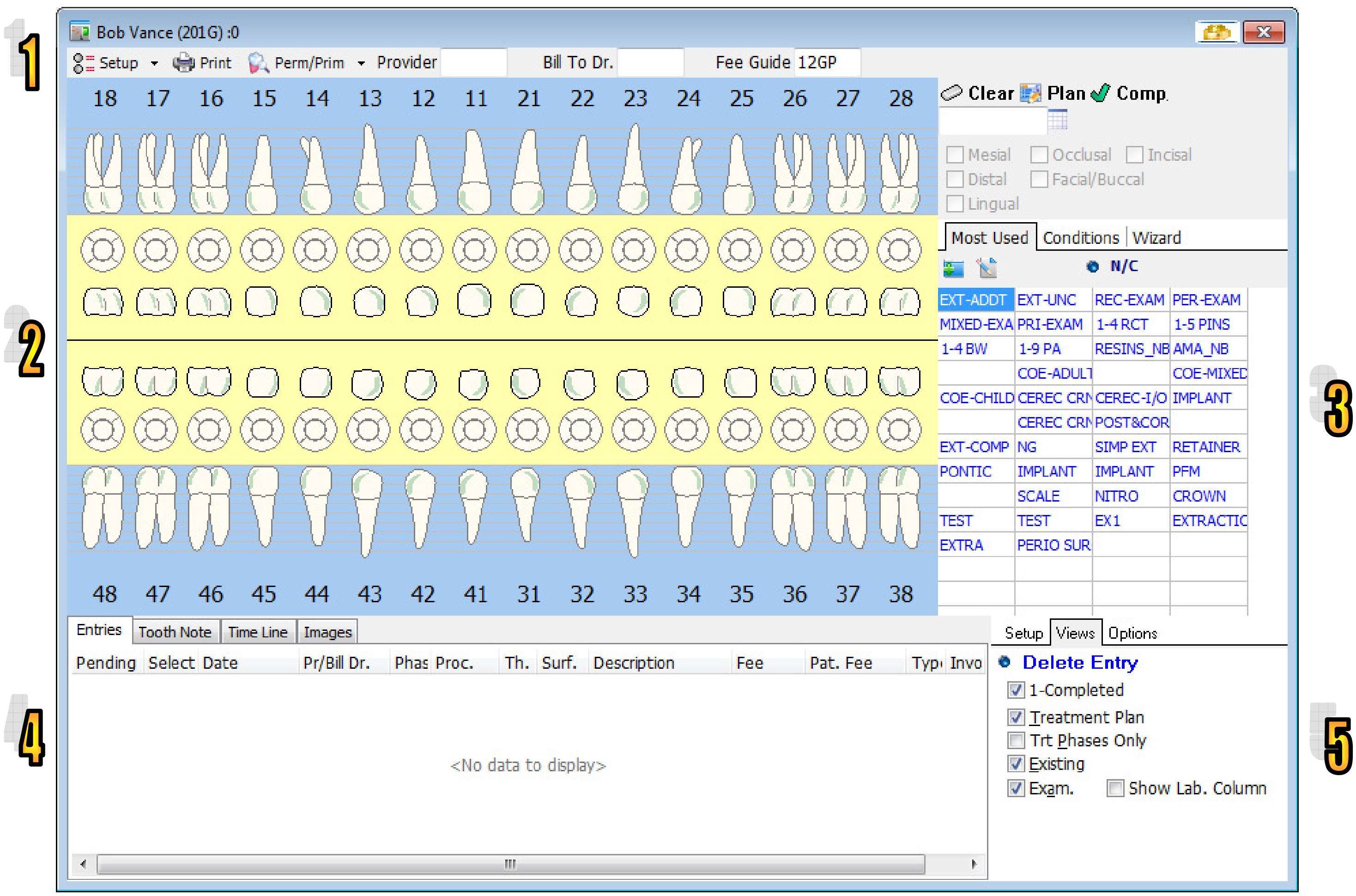


Figure 3.2

3 Treatment Selection Sidebar

- The sidebar is used to enter patient *Conditions*, current *Treatments*, and *Treatment Plans*. The *Most Used* and *Wizard* Tabs store treatment codes that the office may normally use on a day-to-day basis.

- Use the **Plan** button to enter a treatment plan; use the **Comp.** button to enter a completed treatment. If a treatment code is not in this area, insert a custom code (explained later).

- Codes stored in the *Most Used* tab can be changed.

- Modify existing codes in *Most Used*, if necessary. Any treatments that involve surface areas are also entered using the **Treatment Selection Sidebar** (**Figure 3.3**).

- The *Conditions* Tab is used when entering *Existing Conditions*. When entering *Conditions*, the **Plan** and **Comp.** buttons will be replaced by the **E.C.** button. Use this button for entering *Existing Conditions*.

4 Entries Area

- Information about all treatments entered from the ledger or from *Charting* display in this area.
- Notes for each individual tooth can be entered into the *Tooth Note* tab. A tooth on the *Charting Area* must be selected in order to enter a *Tooth Note* (**Figure 3.4**). When a tooth is selected, the name of this tab will change from *Tooth Note* to *Note: xx* where *xx* represents the tooth note (**Figure 3.5**).
- The *Images* tab displays all photos that have been added to the patient's account.

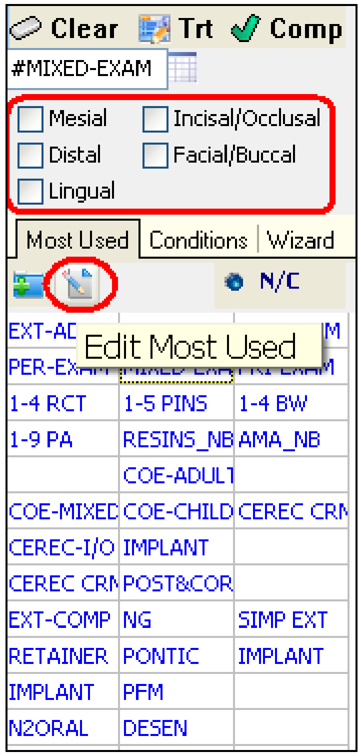


Figure 3.3

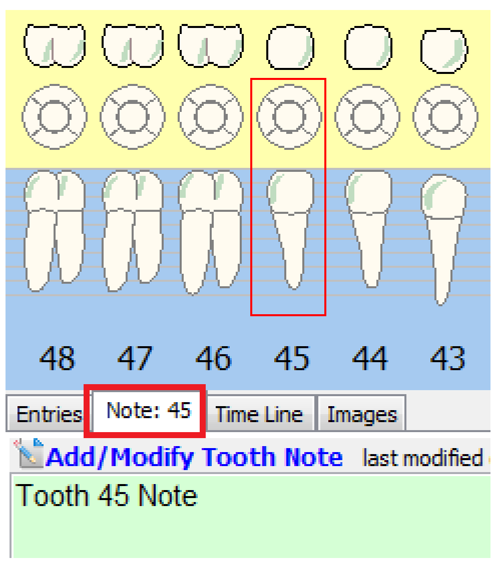
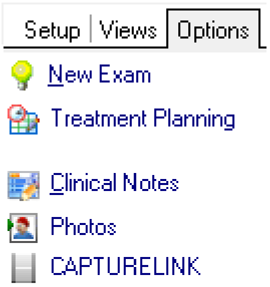
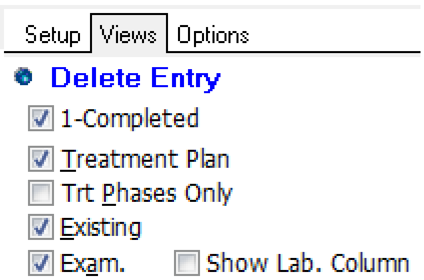


Figure 3.4





Options/Views

This area has multiple applications: the *Options* Tab offers four separate functionalities:

- **New Exam**:

Enter a new patient exam from this area (when entering *Conditions*).

- **Treatment Planning**:

View, edit, and add treatment plan phases from this area. Mark specific treatments as *Pending*, *Approved*, or *Declined* as necessary.

- **Clinical Notes**:

If the **Clinical Notes** module has been purchased and enabled, clicking on this button will open up the main *Clinical Notes* screen.

- ***Views*** Tab:

Change how the *Entries and Charting* areas appear by selecting or unselecting particular checkboxes. If a checkbox is unchecked, then the corresponding treatment entries in the *Entries* and *Charting* area will be hidden.

RESTORATIVE CHARTING SETUP

Colour Setup

Used to change the background of the *Charting* screen as well as the charting *treatment* colours. To do so, click on the *Setup* Tab, and then click on *Colours*. In the *Charting Setup* screen left click on the option to change. A colour box will appear (**Figure 3.7**).

Select the desired new colour, click on the **OK** button, and then click on the **Finish** button back in the *Charting Setup* screen. Close and re-open the chart to see the new changes.

MOST USED SETUP

Quick Tip

You cannot delete any predefined entries under *Most Used.* However, you can **modify** a treatment and change it to something else, thereby eliminating that treatment and at the same time adding another in its place.

Completed Treatments and *Treatment Plans* can be entered into a patient's chart using the *Most Used* and *Wizard* Tabs. Treatment codes in these two areas are codes that an office would use on a daily basis.

Click on a tooth, choose a *Most Used* code, and then choose to enter a *Treatment Plan* or *Completed Treatment*. Use Paradigm's predefined *Most Used* codes, or create and add a new one to the list.

Most Used Screen Overview

The section below will explain how to create *Most Used* codes. The *Most Used Code* screen will be outlined, and there will be instructions to apply a *Most Used* code to a patient's chart.

To access the *Most Used* screen click on the **Setup** Menu, and then click on **Create Most Used**, or alternatively click the button under the *Most Used* tab. The *Charting Most Used* dialog box will open (**Figure 3.5**). Below is an overview of the *Charting Most Used Screen*.

- **Name**:

Type in the treatment code name (ten characters maximum).

- **Description**:

Type in the description of the treatment (30 character maximum).

- **Action**:

Choose what group the code will belong (*Restoration, Inlays,* etc).

- **Service Code**:

Type the desired service code in the *Service Code* field, or use the **File Selection** button to find and insert the proper service code.

- **Active** checkbox:

Marks the code as active or inactive. Inactive codes cannot be used.

- **Unit/Canals Req. checkbox**:

Used with the scroll box underneath to mark a code as needing units or canals.

Quick Tip

Ensure that you know the number of units required when using the *Max Surface* scroll box. If you enter the wrong number, then the treatment entered using this code may not process properly into the chart, or may not process at all.

- **Max Surface/Units/Canals**:

Depending on the treatment code, this option can set a predefined number of service codes to choose from. For instance, if creating a *Most Used* code for pins (21401), you can set the number in the *Max Surfaces* scroll box to **9.**

When entering this treatment from *Most Used*, the program will give 9 options from which to choose, each corresponding with a different service code (24101 to 24109—**Figure 3.6**).

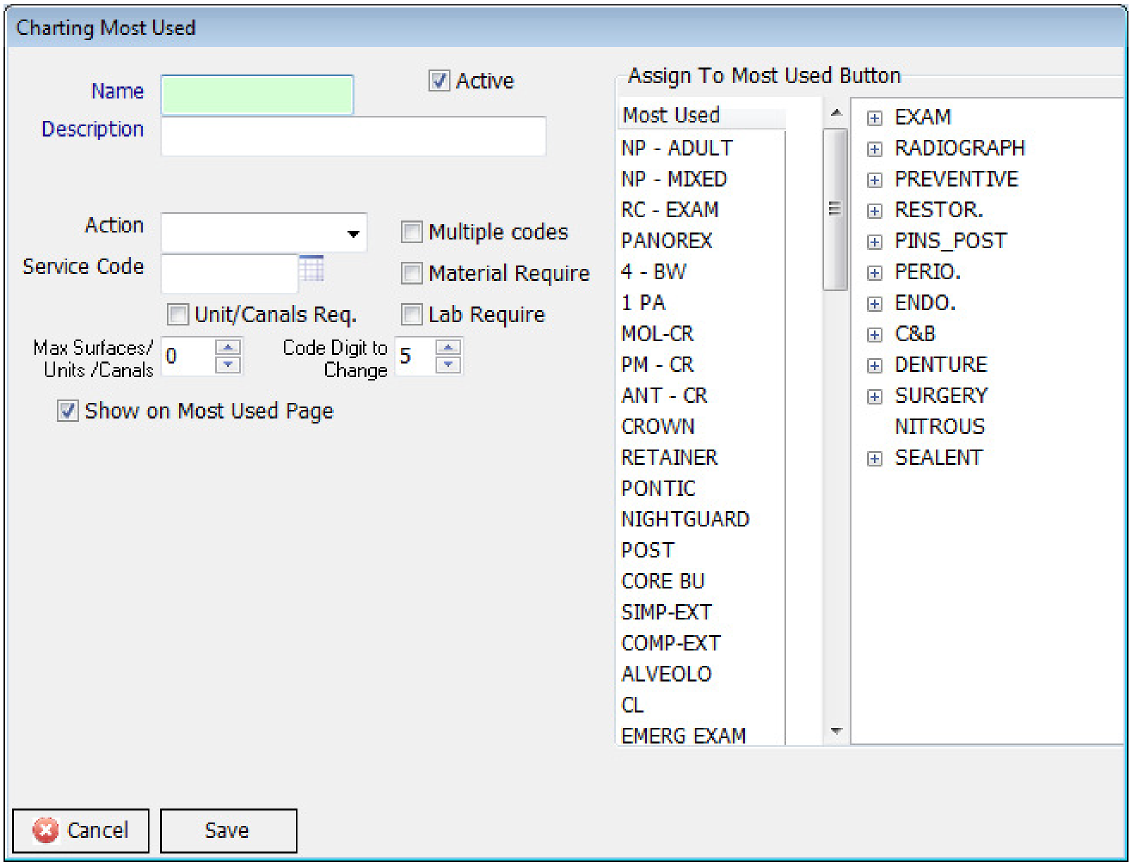


Figure 3.5

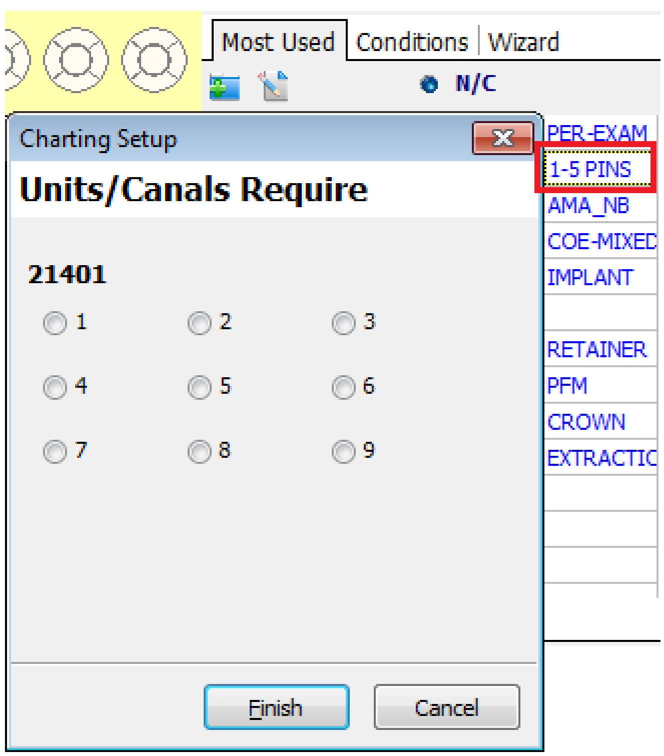


Figure 3.6

➢ **Multiple Codes**:

If a treatment can have more than one service code from which to choose (such as 27211, 27311, 27401), selecting this checkbox will make it so **only** these specific service codes can be selected when entering the treatment (such as a Crown treatment).

When the checkbox is selected, the bottom part of the screen will change, as shown in **Figure 3.7**. To input multiple codes click on the small  button, located at the bottom (a description on how to enter multiple codes is covered later).

➢ **Material Require**:

Indicates whether or not a treatment code needs a material.

➢ **Lab Require**:

Tells the system that a lab fee will be associated with a specific treatment code.

➢ **Code Digit to Change**:

Quick Tip

Only the numbers 4 or 5 can be entered into the *Code Digit to Change* scroll box. The numbers change the second last or last number in a treatment code to match what is entered into a patient's chart.

This scroll box is used in conjunction with the *Max Surfaces/Units/Canals* scroll box. Use this option if a treatment has a specific range (e.g. a pins treatment—2140**1** to 2410**5**). If the number **5** is inserted into the scroll box, then when entering a treatment (pins, for example), the program changes the **fifth** digit of the service code to match the treatment code selection (2410**1**, 2410**2**, etc).

If the number **4** is inserted into the scroll box, then the program will change the fourth code to reflect the treatment entry (e.g. 331**1**1, 331**2**1, etc). The number entered into the *Max Surfaces* scroll box tells Paradigm how many service codes are associated with a particular *Most Used* code.

Use **21401** as an example. If the *Max Surfaces* scroll box has the number **9** entered, and the *Code Digit to Change* box has the number **5**, then when entering this *Most Used* code as a treatment, there will be the option to choose from **nine** service codes. The **last** number in the service code would change to reflect the different service code options (e.g. 2140**1** to 2140**9—Figure 3.8**).

Another example is creating a *Most Used root canal* treatment code (**33111**). If the number **4** is entered into the *Max Surfaces* scroll box, and the number **4** is entered into the *Code Digit to Change* box, then there will be the option to choose from **four** different codes, with the **second last** number changing to reflect the different service code options (e.g. 331**1**1; 331**2**1; 331**3**1; 331**4**1—**Figure 3.9**).

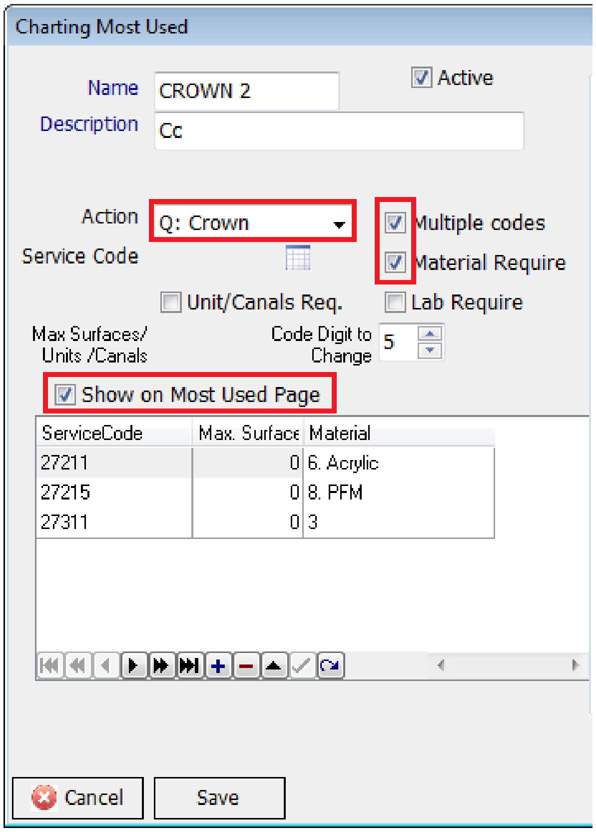


Figure 3.7

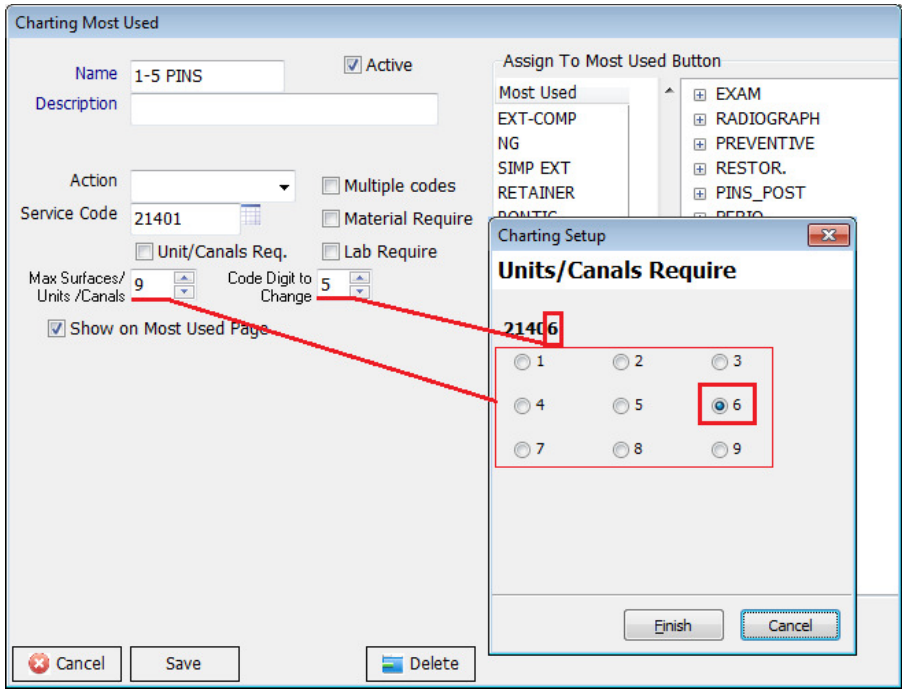


Figure 3.8

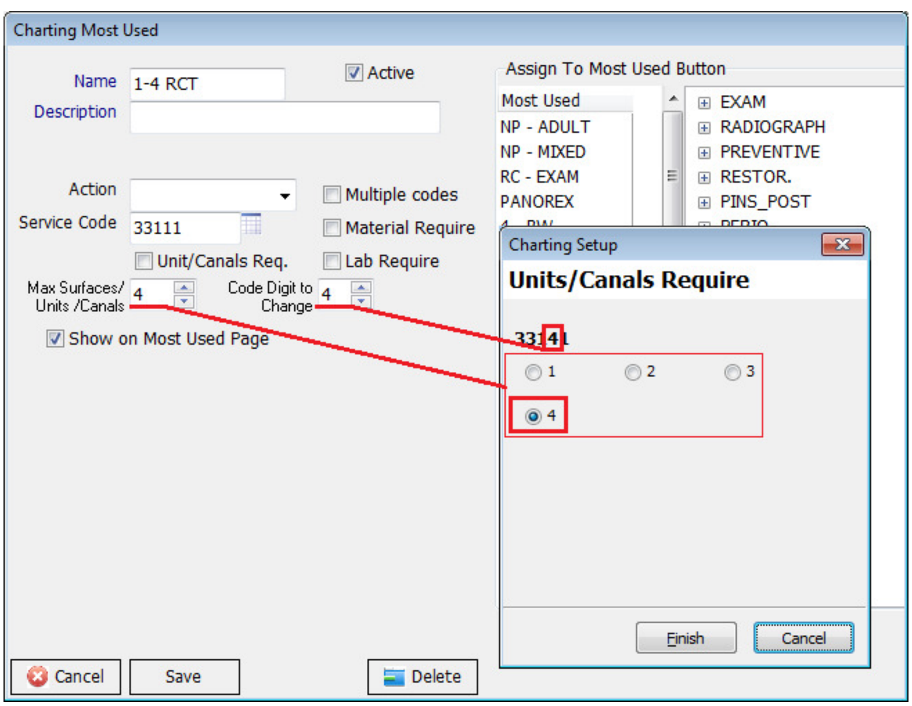


Figure 3.9

Show on Most Used Page:

Codes will appear under the *Most Used* Tab in the charting window only if the "Show on Most Used Page" option is selected. It will not appear under the *Wizard* Tab (items appearing in the *Wizard* Tab will be discussed later).

- *Assign Most Used Button* columns

Pre-existing *Most Used* codes are stored in this area. You can add or modify codes to this area (covered later).

Creating Most Used Codes

Researching Multiple Code Entries

When entering a *Most Used* code using the **Multiple Codes** feature, note that some treatment codes (such as Inlays, Crowns, or Root Canals) are predefined with certain materials. Before adding new *Most Used* codes, it must be known how these codes are defined within Paradigm. To see how a treatment code is defined, click on the **File** drop-down arrow on the top left-hand side of the *Appointment Book*, select **Service Code,** and then **Service Code** again. Find the appropriate code, left click on it, and click on the **Modify** button on the bottom of the screen (**Figure 3.10**).

In the *Modify* screen click on the *Charting* Tab. Underneath will be two drop-down boxes. The first box defines the treatment code (restorative, crown, etc). The second box displays the material defined for a specific code. When creating a *Most Used* code that has materials, whatever is entered for that code **must** match what is in this area. If there is nothing in this area, then define the code any way as needed (**Figure 3.11**).

Click on the *Billing Entry* tab. In order for a treatment code to appear on the charting area, the **Tooth Require** checkbox must be selected, and specific tooth numbers must be entered within the **1st digit** and **2nd digit** boxes (**Figure 3.12**). Furthermore, if a specific treatment code(s) needs to have a lab associated with it, then the **Lab. Require** checkbox must be selected. If any changes are made in this screen, ensure to click on the **Save** button. Otherwise, click on the **Cancel** button.

Viewing Most Used Codes

As mentioned earlier, **Restorative Charting** is set up with preconfigured *Most Used* codes. If the **Charting** module is being loaded for the first time, it is **strongly recommended** to **not** create new *Most Used* codes, or edit pre-existing codes until becoming more familiar with the normal **Charting** features**.**

To see the properties of a *Most Used* code, left click on a code under the *Most Used* Tab, and then click on the **Edit Most Used** button .

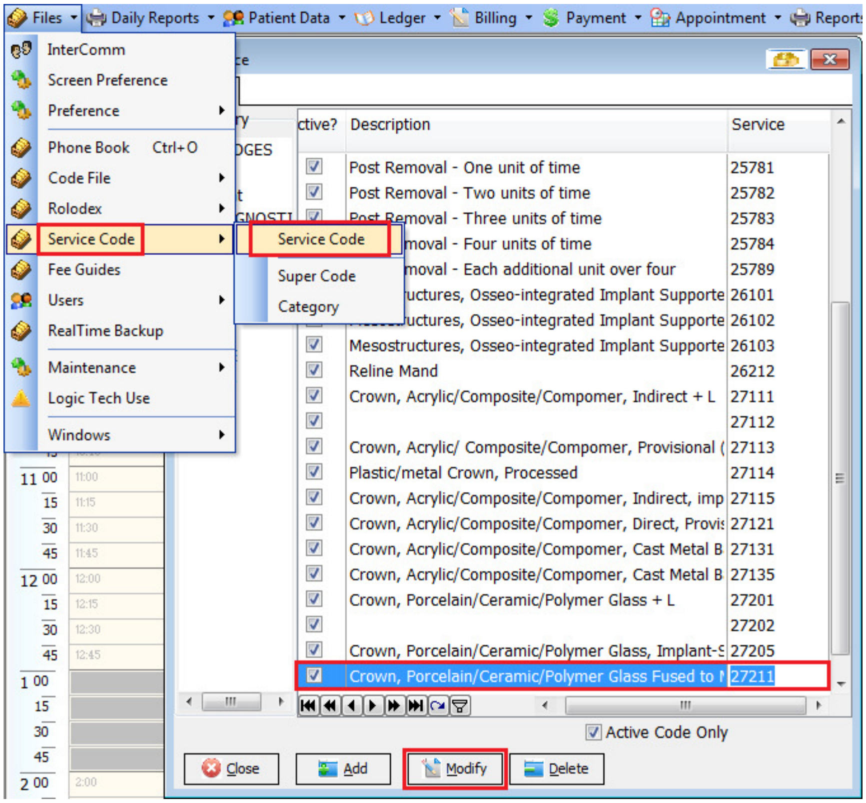


Figure 3.10

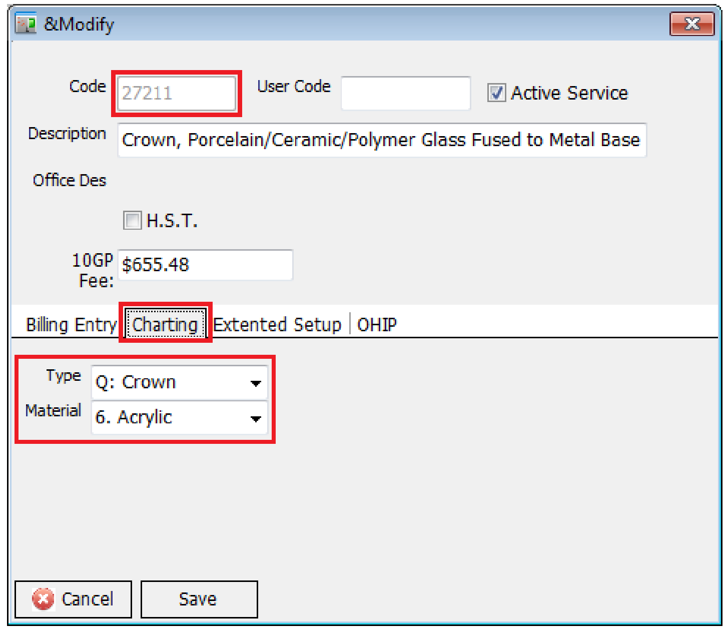


Figure 3.11

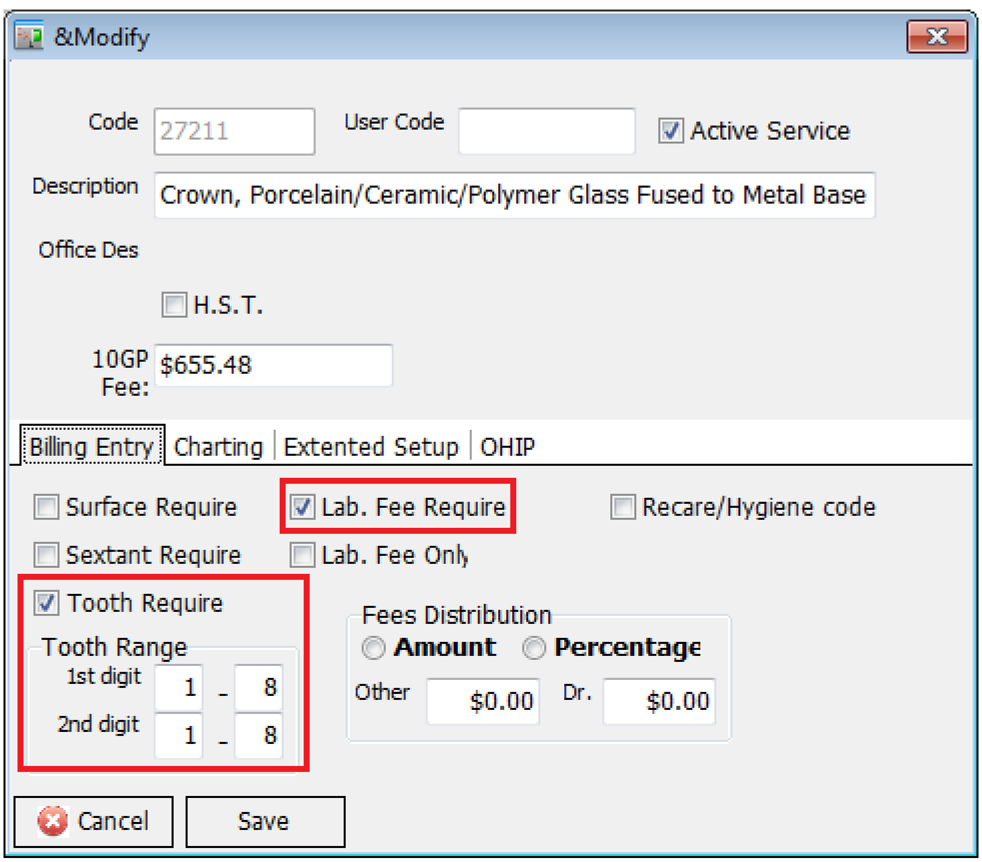


Figure 3.12

Note that *Most Used* treatments *cannot* be deleted. They can, however, be edited to represent another treatment code.

Creating Most Used Codes: Multiple codes

> **Quick Tip**
>
> Note that if the **Multiple Codes** checkbox is selected, then the **Max Surface** checkbox as shown in **Figure 3.7** will disappear.

1. If the parameters of a specific treatment code are already known, access the **Charting** program and click on the **Create Most Used** button. If it is uncertain whether a code belongs to a specific charting type, follow the instructions on page 36 to investigate.

2. Type in the name of the code treatment within the *Description* field, and up to 10 digits within the *Name* column.

3. If the code belongs to a certain group (such as Restoration, Implant, Crown, etc), then click on the **Action** drop-down arrow and select the correct option. Again, if it is uncertain whether a code belongs to a specific charting type, follow the instructions on page 36 to investigate.

4. Next, place a checkmark in the **Multiple Codes** checkbox. If the codes use a certain material, place a checkmark in the **Material Require** checkbox.

> **Quick Tip**
>
> Notice that when the **Multiple codes** checkbox is selected, the *Max Surfaces/Units/Canals* scroll box becomes unavailable.

5. If a lab fee is associated with the treatment codes, place a checkmark in the **Lab Require** checkbox. In the bottom portion of the screen, click on the small button, located at the bottom, and then manually type the appropriate service code under the *ServiceCode* column (**Figure 3.13**).

6. If a default material is used with a specific code, click on the *Material* column. A drop-down menu will appear. Choose the appropriate material from the menu.

7. After entering a service code, click on the button, and then click on the button to enter the next code. If a specific service code has surfaces, enter the surface number under the *Max. Surface* column. Perform the same steps until the desired number of service codes are entered.

8. Ensure that the **Show on Most Used Page** checkbox is selected, then click on the **Save** button, and then on the **Cancel** button to close the screen. Close and reopen *Charting* to see the new *Most Used* code.

Creating Most Used Codes: Single Codes

If there is a single treatment code that the office uses on a daily basis (71101—extraction, for example), it can be added to the *Most Used* area in the following way:

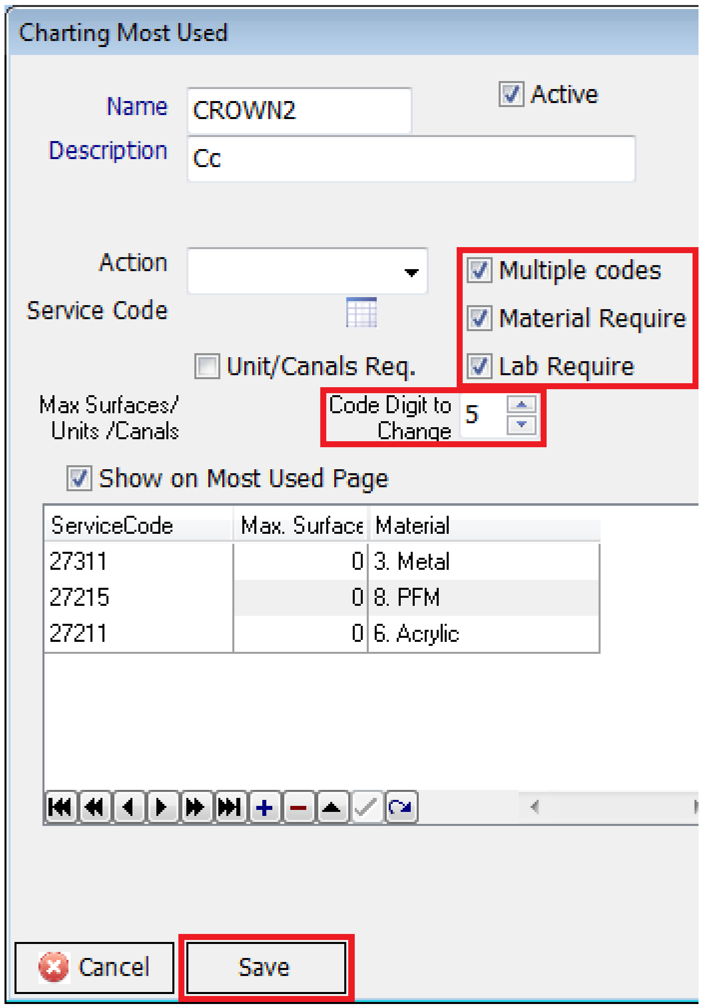

Charting Most Used
Name
CROWN2
Active
Description
Cc
Action
Service Code
Multiple codes
Material Require
Lab Require
Unit/Canals Req.
Max Surfaces/ Units /Canals
Code Digit to Change
5
Show on Most Used Page
ServiceCode
Max. Surface
Material
27311
0
3. Metal
27215
0
8. PFM
27211
0
6. Acrylic
Cancel
Save

Figure 3.13

1. Click on the **Create Most Used** button . Type in the name of the code treatment within the *Description* field, and up to 10 digits within the *Name* column.

2. If the code belongs to a certain group (such as Restoration, Implant, Crown, etc), then click on the **Action** drop-down arrow and select the correct option. If it is uncertain whether a code belongs to a specific charting type, follow the instructions on page 36 to investigate.

3. Next, enter the proper service code in the **Service Code** box.

3a. **OPTIONAL:** If there is a range for a specific code, such as scaling 11111 to 11116 (note that the service code 11117 **cannot** be entered as it is a half-unit of scaling), place a checkmark in the **Unit/Canals Req.** checkbox. Enter the appropriate number in the *Max Surfaces/Units/Canals* scroll box, and then change the number in the **Code Digit to Change** scroll box, if needed (**Figure 3.14**).

4. Click on the **Lab Require** checkbox if a lab is associated with the treatment code. Ensure that the **Show on Most Used Page** checkbox is selected, then click on the **Save** button, and then click on the **Cancel** button to close the screen. Close and reopen *Charting* to see the new *Most Used* code.

ENTERING CONDITIONS, COMPLETED TREATMENTS, TREATMENT PLANS

Conditions are either pre-existing treatments that a patient had before becoming a patient of the office (such as a root canal provided by another dentist), or current conditions, such as bleeding, chipped, or cracked teeth. A *Condition* that is entered into a patient's chart will display by default as the colour Green. *Conditions* are entered in the following manner (**Figure 3.15**):

> **Quick Tip**
>
> When entering *Existing Conditions*, you can select the appropriate teeth as explained in these instructions, or you can choose the condition first, and then select the teeth.

1. Left click on the desired tooth within the *Charting* area.

2. Click on the *Conditions* tab. Use the scrollbar located further to the right to find the desired *Condition*. Left click on the *Condition* to select it.

3. Click on the **E.C.** button. The *Conditions* should appear within the *Charting* area, as well as within the *Entries* Tab (**Figure 3.16**).

4. *Conditions* can be removed within the *Entries* Tab (**Figure 3.16**). Right-click on the *Condition* and then Left-click on delete.

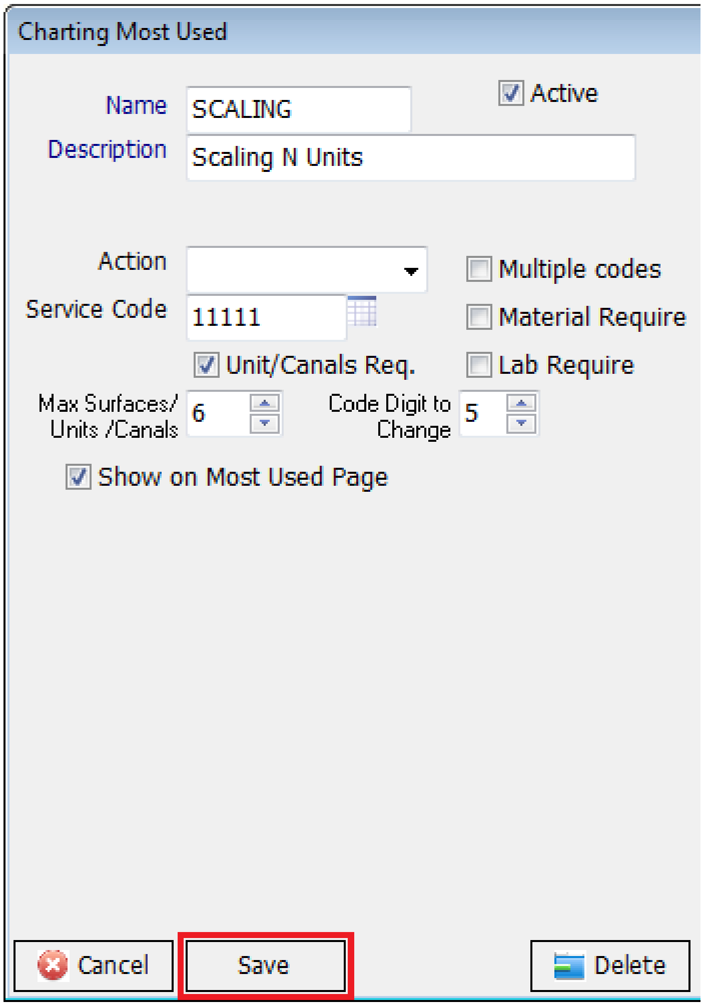


Figure 3.14

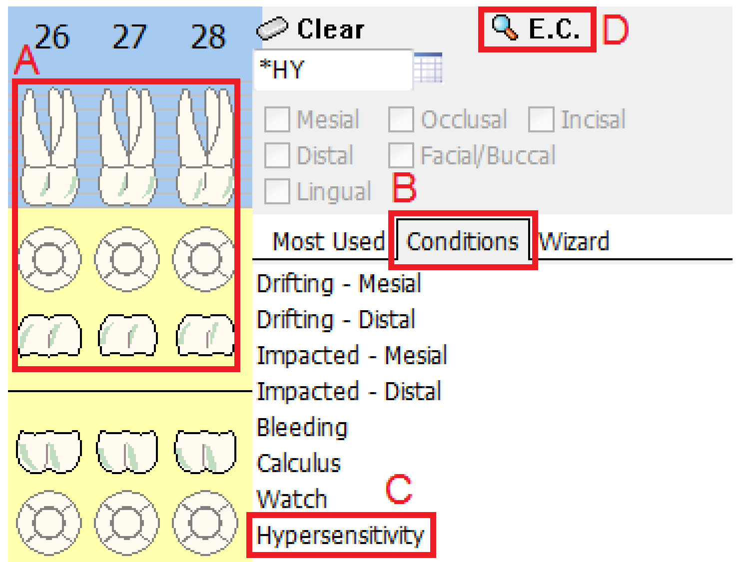
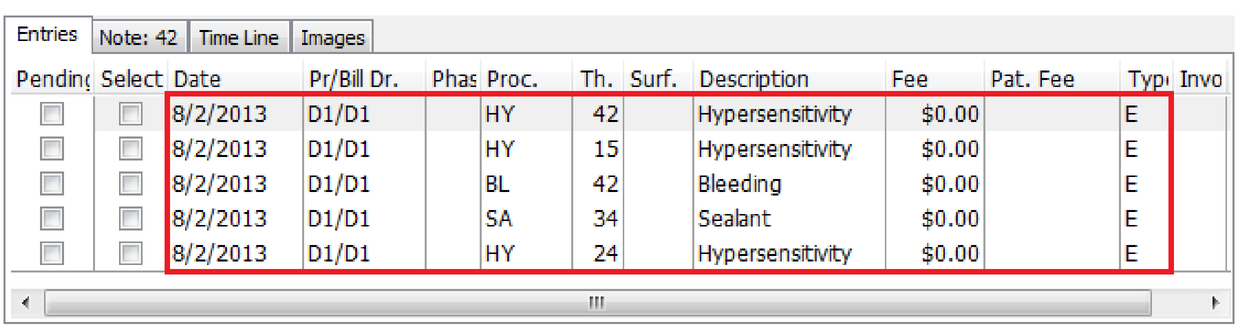


Figure 3.15



Pendin(	Select	Date	Pr/Bill Dr.	Phas	Proc.	Th.	Surf.	Description	Fee	Pat. Fee	Typ	Invo
		8/2/2013	D1/D1		HY	42		Hypersensitivity	$0.00		E	
		8/2/2013	D1/D1		HY	15		Hypersensitivity	$0.00		E	
		8/2/2013	D1/D1		BL	42		Bleeding	$0.00		E	
		8/2/2013	D1/D1		SA	34		Sealant	$0.00		E	
		8/2/2013	D1/D1		HY	24		Hypersensitivity	$0.00		E	

Figure 3.16

ENTERING COMPLETED TREATMENTS

Completed Treatments and *Treatment Plans* can be entered into a patient's chart using the *Most Used* or the *Wizard* Tabs. Note that once a *Completed Treatment* is entered into a patient's chart, it will display by default as the colour Blue.

> **Quick Tip**
>
> Note that entering codes that have nothing to do with the **Charting** module (such as service code 11111) **will** display in the *Entries* tab, but will **not** show any information in the actual *Charting* area.

Completed Treatments – Most Used

1. To enter a *Completed Treatment* using the *Most Used* Tab, first select the required tooth or teeth by left clicking on the correct tooth numbers, located on the *Charting* area.

2. Once the teeth are selected, left click on the appropriate *Most Used* code. Notice that the surface checkboxes above are now available. If the *Most Used* code has surfaces (for an Amalgam treatment, for example), check the appropriate surface checkboxes (**Figure 3.17**).

> **Quick Tip**
>
> It is important to note that any treatment code can be entered into a patient's chart. All charting entries will appear in the *Entries* tab. Furthermore, any treatment codes that were entered in the ledger will also appear in the *Entries* tab.

3. Click on the **Comp.** butto 

(located on the upper-right) to insert the selected treatment code into the patient's chart (**Figure 3.17**). If a lab fee is associated with a specific *Most Used* code or if it has a material associated with the treatment code, then a *Charting Setup* box will appear (**Figure 3.18**).

4. Enter the lab fee amount, choose the correct material (if applicable), and then click on the **Finish** button. The *Charting* area should now display the treatment code(s) entered. These codes should also appear under the *Entries* tab, showing the detail of the treatment entries.

5. Although the *Completed Treatments* are now inserted into a patient's chart, they are not yet solidified within the chart. Notice that the *Pending* column in **Figure 3.19** shows some treatments have checkmarks under the *Pending* column.

> **Quick Tip**
>
> After you enter a *Completed Treatment*, you can post the treatment to your ledger and patient's chart right away. If you choose to not post the treatment, it will remain as a pending status until posted.

6. To complete the treatment (post it to a patient's ledger), click on the **Save** button on the top left of the *Charting* screen, and then click on **Post all Pending Entries** (**Figure 3.20**). This completes **all** entries that have a checkmark under the *Pending* column. Alternatively, place a checkmark in the *Select* column next to the entries to complete, and then click on **Save**, and **Complete Selected Entries**.

7. A *Billing Options* dialog box will appear. If the treatments are to be billed to the patient, click on **Bill to Patient**. If they are to be billed to the Insurance, click on **Bill to Insurance**. Lastly, click on the **Finish** button. The treatments are now posted to the patient's ledger as well as the patient's chart.

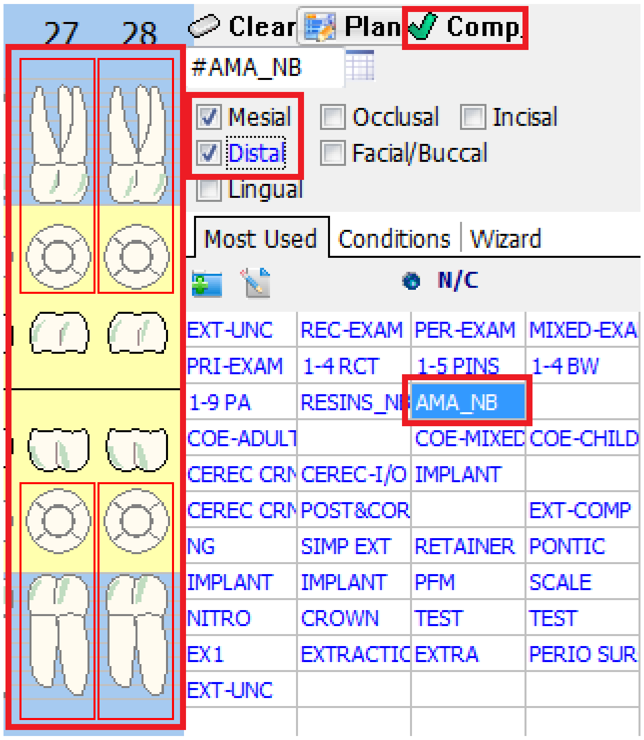


Figure 3.17

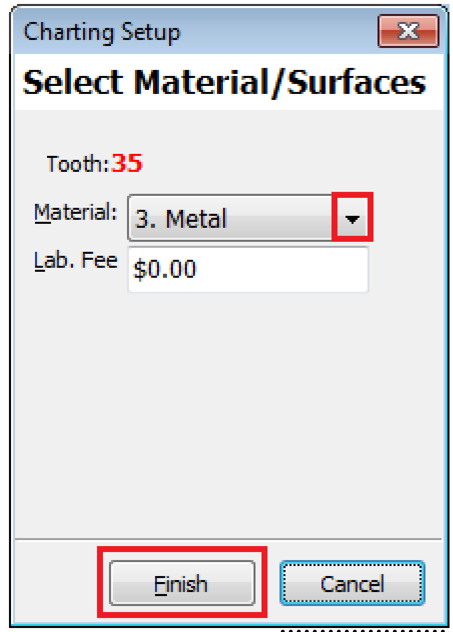


Figure 3.18

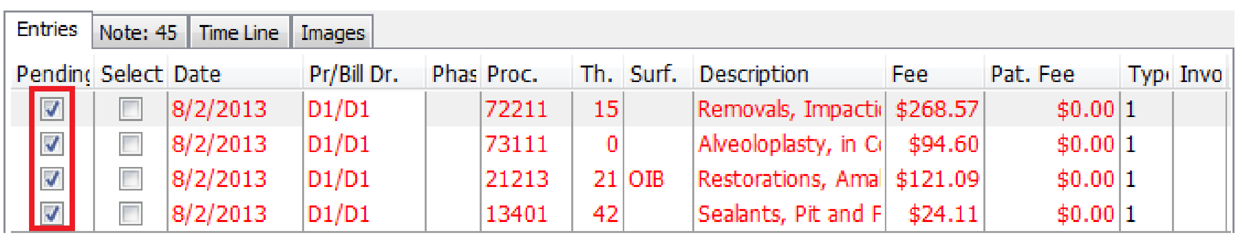


Figure 3.19

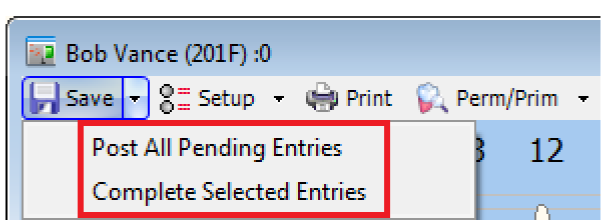


Figure 3.20

Completed Treatments – Wizard

Use the *Wizard* tab if unsure of the exact treatment code to enter into a patient's chart.

1. Select the required tooth or teeth by left clicking them on the *Charting* area, and then click on the *Wizard* tab.

Notice that there are two types of buttons within this area. The buttons with a name on it can be selected to enter a treatment. Whatever button is selected will show a specific code within the blank box underneath the **Clear** button. The buttons with the drop-down arrow can be selected to view a list of treatments (**Figure 3.20**).

2. To enter a treatment click on the desired option, and then click on the **Comp.** button. The *Charting Setup* screen may appear, depending on what is selected. Choose the correct material or units if necessary, and click on the **Finish** button (**Figure 3.21**). The selected entry should now show in the charting *Entries* areas.

3. To complete the treatment (post it to the patient's ledger), click on the **Save** button on the top left of the *Charting* screen, and then click on **Post all Pending Entries**. Alternatively, place a checkmark in the *Select* column next to the entries to complete, and then click on **Save**, and **Complete Selected Entries** (**Figure 3.22**).

4. A *Billing Options* dialog box will appear (**Figure 3.23**). If the treatments are to be billed to the patient, click on **Bill to Patient**. If the treatments are to be billed to the Insurance, click on **Bill to Insurance**. Lastly, click on the **Finish** button. The treatments are now posted to the patient's ledger as well as the patient's chart.

When to use Most Used or Wizard

Using *Most Used* or the *Wizard* to enter treatments is up to personal preference. Using a Crown as an example, *Most Used* is most useful for entering frequently used treatments (such as 27211 with Plastic; 27311 with Metal; 27215 with PFM), or for service codes with ranges (i.e. 11111 to 11116, 33111 to 33141).

The *Wizard* tab has predefined codes stored in this area. Use the *Wizard* when unsure exactly which treatment is to be applied.

Entering treatments using the *Treatment Entry Box* simply means manually typing in, or selecting the treatment code each time to enter a treatment into a patient's chart. This option is useful if it is known what treatment code to use. Use the entry process that best suits the office needs.

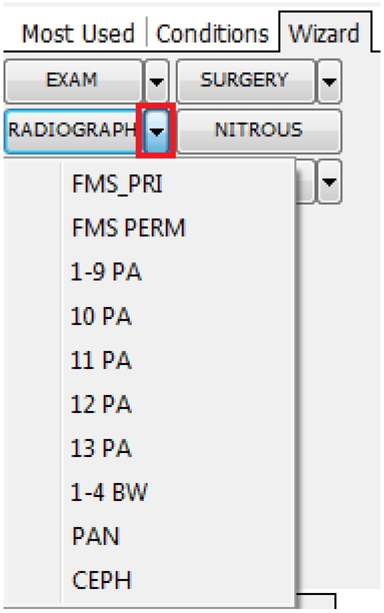


Figure 3.20

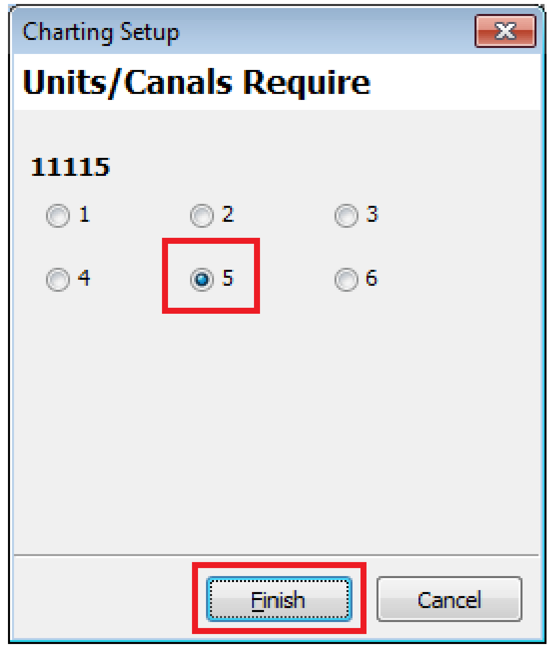


Figure 3.21

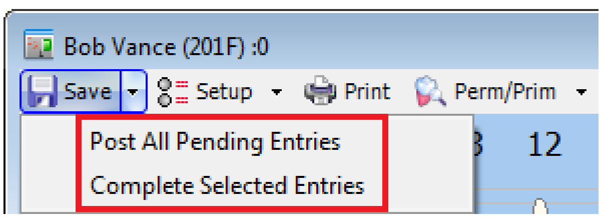


Figure 3.22

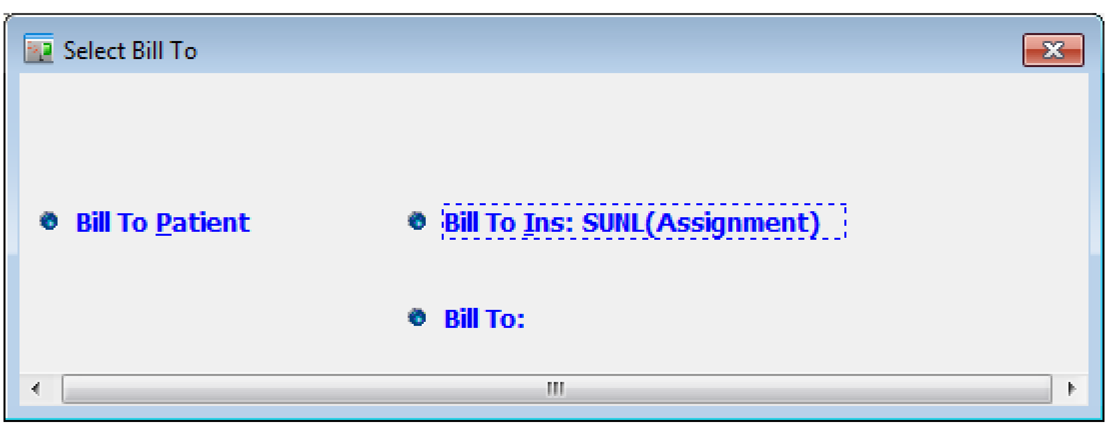


Figure 3.23

TREATMENT PLANS

Quick Tip

Before you use *Treatment Phase Management*, ensure that the patient has planned treatments in their ledger.

Treatment Plans are entered into a patient's chart using the same methodology as entering *Completed Treatments*. The only difference when entering a treatment is to click on the **Plan** button instead of the **Comp.** Button. Once a *Treatment Plan* is entered into a patient's chart, it will display by default as the colour Red.

Treatment Phases Management

Treatment Plans can be added to the **Charting** *Treatment Phase Management* system. *Treatment Planning* enables assigning treatment plan entries to a desired phase number. Assign a *Planned Appointment* to different phase numbers, and then give this information to the patient.

The printout will show when the treatments are scheduled, what will be performed, and what the patient owes as of each treatment.

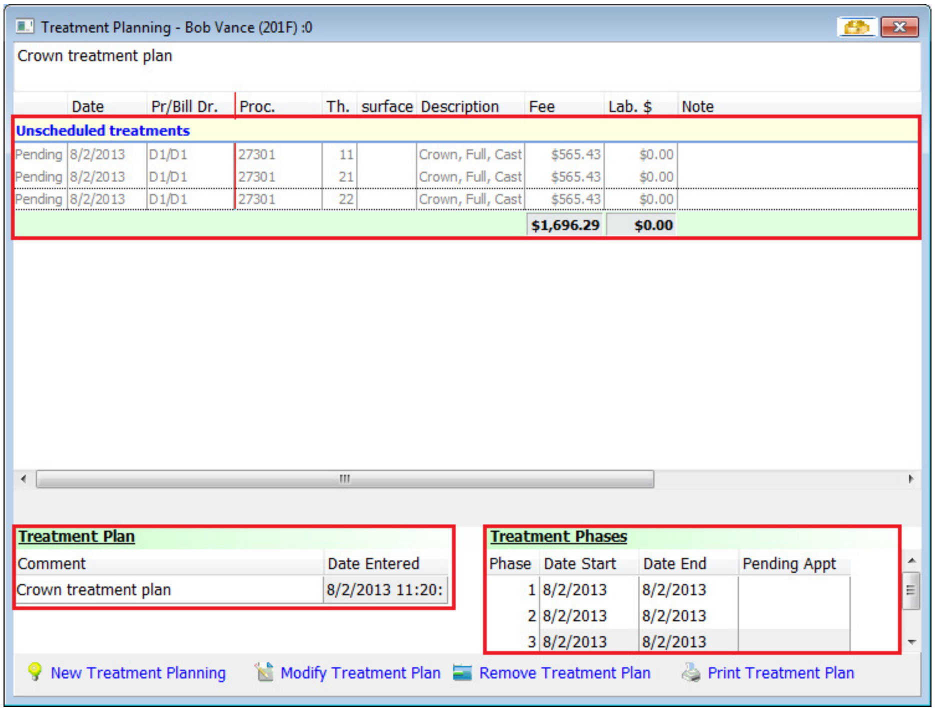


Figure 3.24

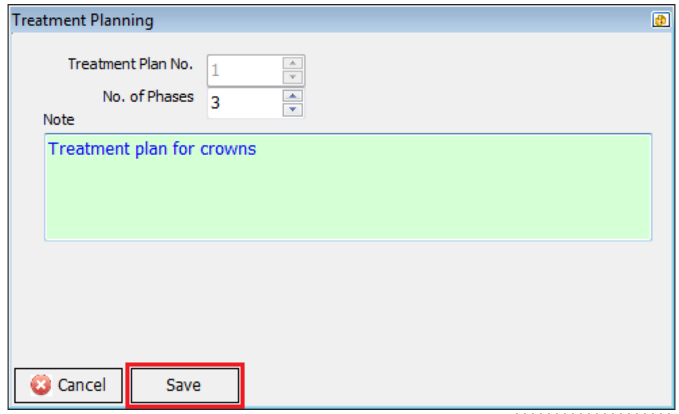


Figure 3.25

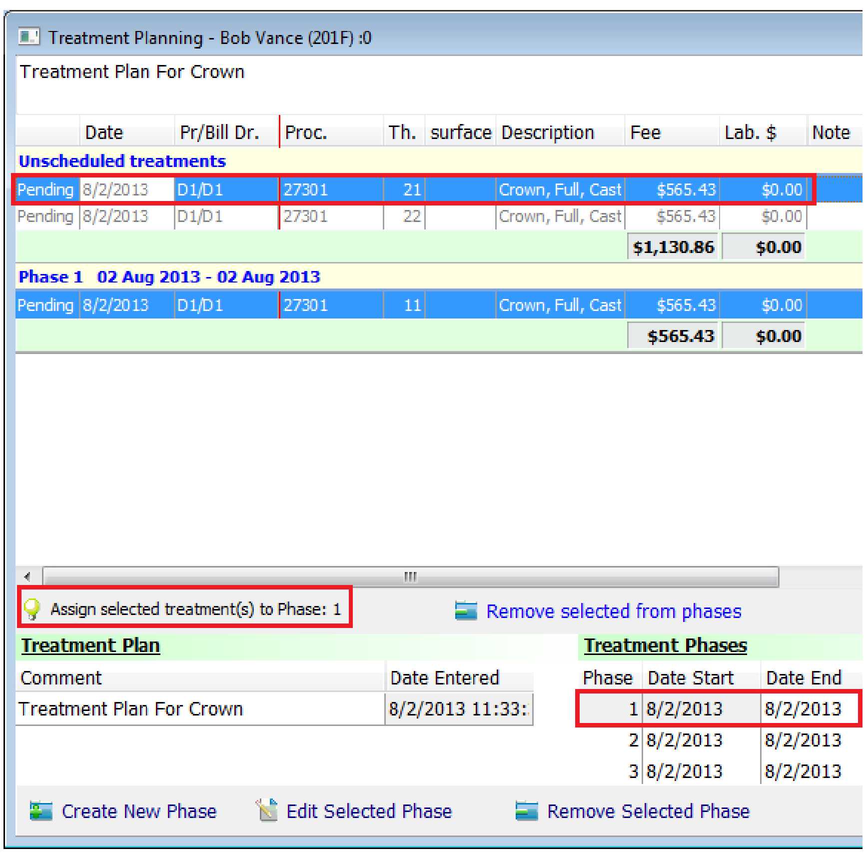


Figure 3.26

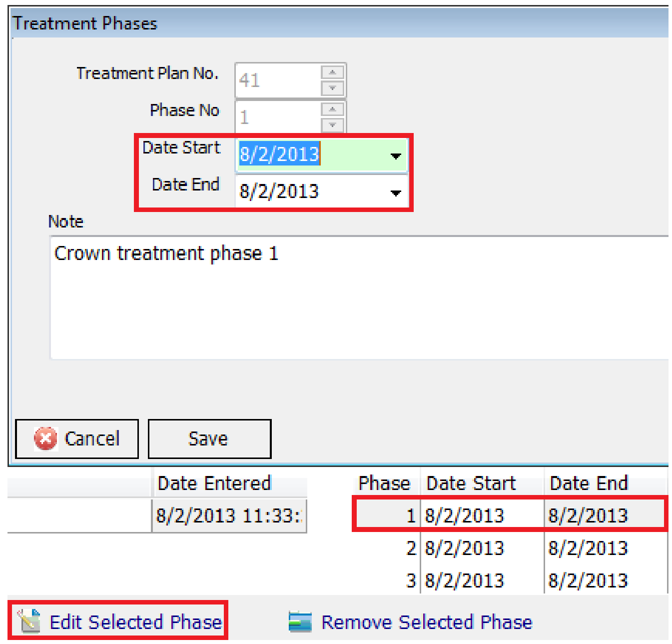


Figure 3.27

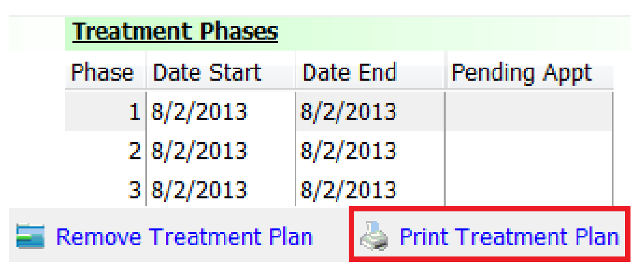


Figure 3.28

Treatment Planning basic functionality:

1. Click on the **Treatment Planning** button located on the bottom right-hand side of the *Charting* screen. The *Treatment Plans Phases/Status Management* window will open.

   Notice that the top portion of the window shows all the treatment plans that have not yet been assigned to a specific phase. The bottom part of the window shows existing treatment plans and their respective treatment phases (**Figure 3.24**).

2. The first step is to create a Treatment Plan. Click on the **New Treatment Planning** button, located on the bottom left-hand side. Define the number of Treatment Phases in this window and a Note for this Treatment Plan can also be left (if desired). Click on the **Save** button (**Figure 3.25**). A new treatment plan with the requested number of phases is created.

3. Double Left-click on the created treatment plan under the *Treatment Plan* section. The Phases for the treatment plan will appear in the *Treatment Phases* section on the right side.

4. Select Phase 1 by left-clicking on it. Then select a treatment from the *Unscheduled treatments* section above. Click on the blue **Assign selected treatment(s) to Phase** button to assign the selected treatment to the phase (**Figure 3.26**). Note that the treatment disappears from the *Unscheduled treatments* section, and now appears under the *Phase 1* section.

   Multiple treatments can be assigned to one Phase by repeating this procedure.

5. To continue assigning treatments to the rest of the Phases in the Treatment Plan, repeat **Step 4** for all the Phases created in the Treatment Plan.

6. In order to change the Start Date and End Date for the Treatment Phase, left-click onto the Treatment Phase to be changed. Then at the bottom of the widow, click onto the **Edit Selected Phase** button. The Starting Date and Ending Date for the phase can be changed in this window (**Figure 3.27**). Click on **Save** to save the changes to the selected Phase.

7. To print a Treatment Plan, double left-click on the name of the Treatment Plan listed under the *Treatment Plan* section. Left-click on the **Print Treatment Plan** button in the bottom right (**Figure 3.28**). A preview of the printout will appear. Left-click on the printer icon found in the top left to print the Treatment Plan.

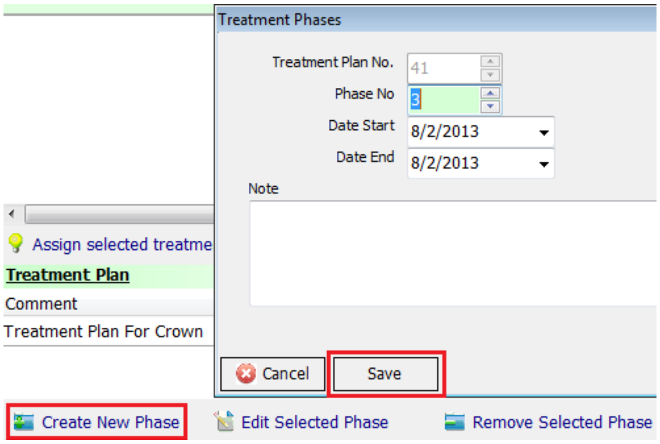


Figure 3.29

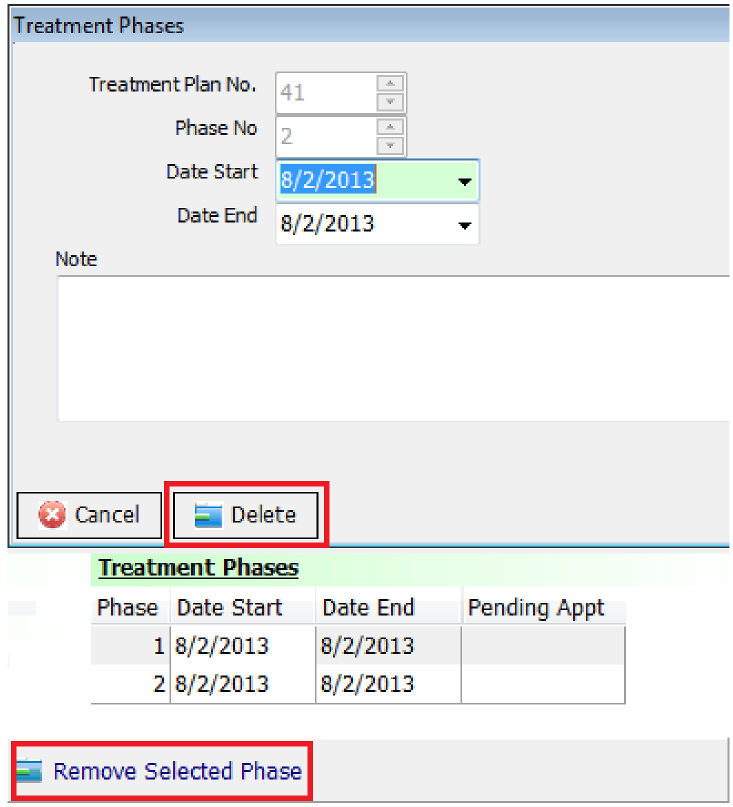


Figure 3.30

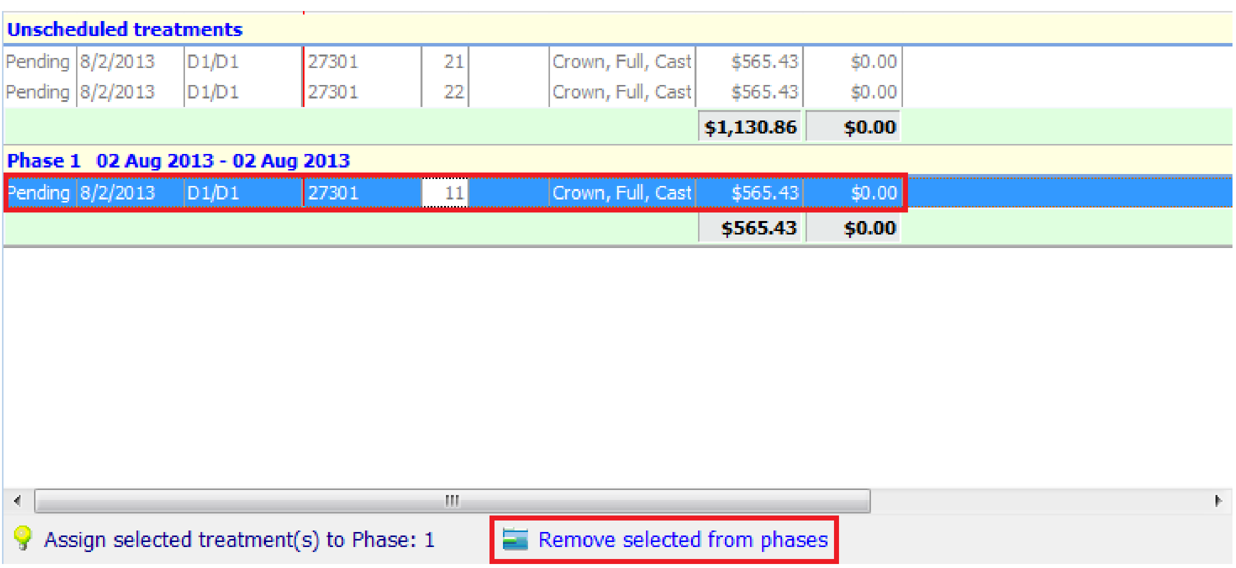


Figure 3.31

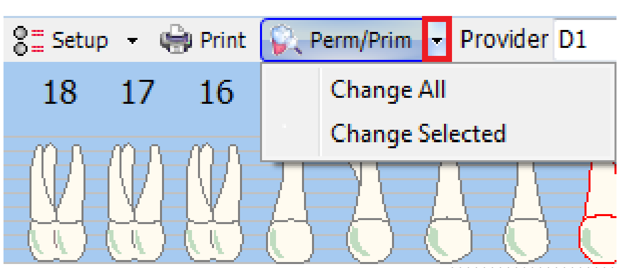


Figure 3.32

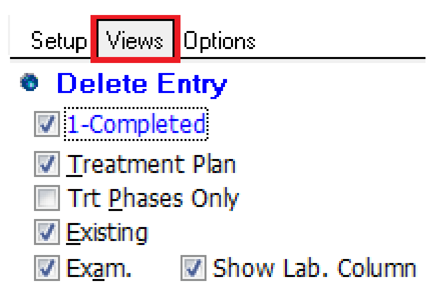


Figure 3.33

Creating/Modifying/Deleting Treatment Phases

New Treatment Phases can be created for existing Treatment Plans. Double left-click on the Treatment Plan in the *Treatment Plan* section to select it. Then click on the **Create New Phase** at the bottom to create a new Treatment Phase (**Figure 3.29**).

Treatment Phases can be deleted if necessary. Double left-click on a Treatment Phase to select it. Then left-click on the **Remove Selected Phase** button at the bottom of the window. Left-click on Delete to remove the Treatment Phase (**Figure 3.30**). Any planned treatments previously assigned to the deleted Phase will be returned to the *Unscheduled treatments* section.

If a treatment needs to be moved to another Treatment Phase, it can be removed from its current Phase and reassigned. Left-click on the treatment to be removed under the *Phase* section (**Figure 3.31**). Click on the **Remove selected from phases** button. The selected treatment will be moved to the *Unscheduled Treatments* column. It can now be reassigned to the another phase.

OTHER CHARTING FUNCTIONS

Primary Teeth

Quick Tip

After changing **all** permanent teeth to primary teeth, clicking again on the **Perm/Prim** button, and then **Change All** will change all primary teeth back to permanent teeth.

By default, a patient's chart shows permanent teeth only. Working on children's teeth will require changing the permanent teeth to primary teeth. To do so, click on the **Perm/Prim** button (located on the top-left of the Charting toolbar), and then click on **Change All**. The chart will now show primary teeth only.

As a child's primary teeth are replaced with permanent teeth, these changes can be shown on his or her chart. Change one or more teeth at a time by clicking on the appropriate teeth, clicking on the **Perm/Prim** button, and then clicking on **Change Selected** (**Figure 3.32**). The selected teeth will then change from primary to permanent.

Views

Click on the *Views* tab, selecting or unselecting specific checkboxes will change how the *Entries and Charting* areas appear. If a checkbox is unchecked, then the corresponding column in the *Entries* and *Charting* area will disappear (**Figure 3.33**).

- **Completed:** Shows only completed treatments.
- **Treatment Plan**: Shows only treatment plans.
- **Trt Phases Only**: Shows only treatment plans that have been entered into particular phases.
- **Existing**: Shows existing conditions entered from the *Conditions* Tab.
- **Exam**: Shows any entries that have been designated as an exam (option not available).

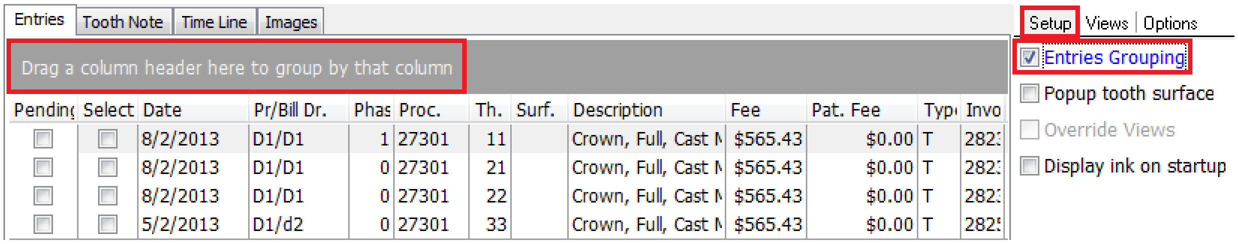


Figure 3.34

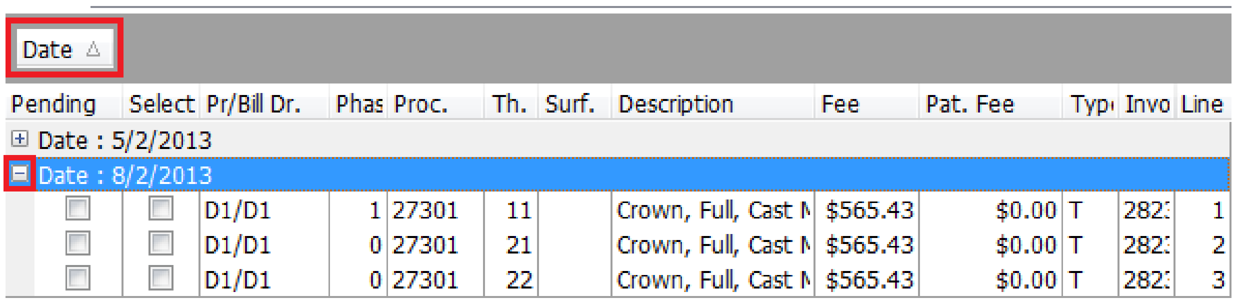


Figure 3.35

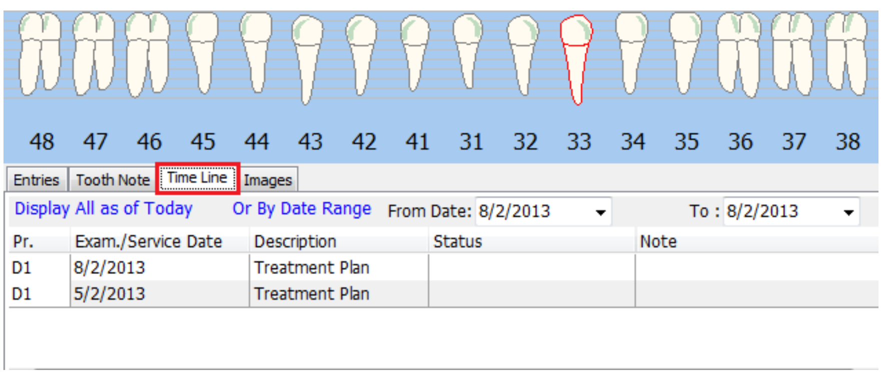


Figure 3.36

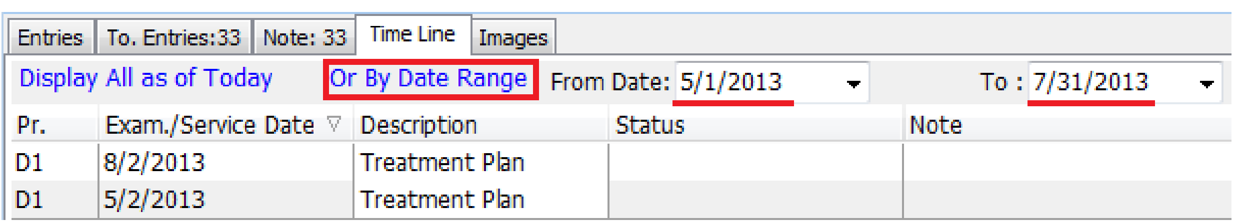


Figure 3.37

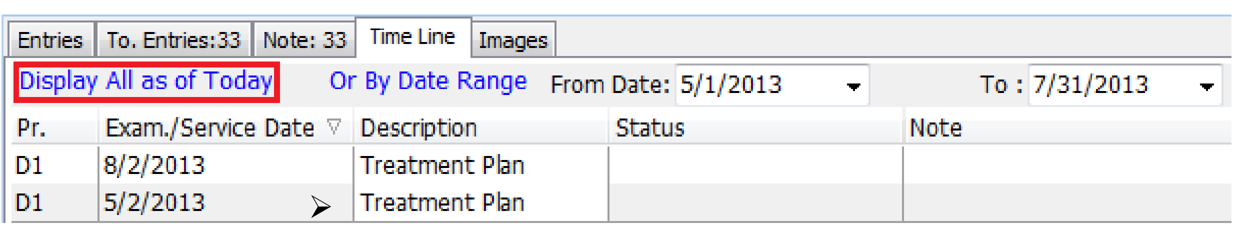


Figure 3.38

Show Lab. Column: Displays a lab column in the *Entries* area. Any treatment that has had a lab attached to it will show under this column.

Setup

Entries Grouping

The *Entries Grouping* option is disabled by default. If enabled, this option allows grouping of information in the *Entries* area under a certain column or columns. If the **Entries Grouping** checkbox is checked, a grey bar will appear just above the *Entries* area (**Figure 3.34**). Left click and **hold** the mouse button on a specific column, drag it over the grey bar, and then let go of the mouse button.

The information in *Entries* will then be grouped by that column. Do this as many times as desired, but is recommended to group no more than three columns, as the information might be hard to decipher with more than three grouped columns. Once a column is grouped, click on the plus sign [+] to the left to expand the grouped column (**Figure 3.35**).

CHARTING TIME LINE

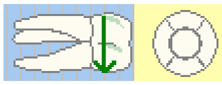
The *Time Line* in charting keeps track of patient Treatments over time. By default the Charting odontogram will display *all* of the selected patient's treatments. The *Time Line* function allows the odontogram to display patient treatments in a date-sensitive manner.

Time Line can be accessed by left-clicking on the tab found under the odontogram (**Figure 3.36**).

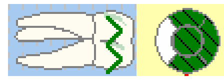
To configure the odontogram to show only the treatments entered in a specific time range, define a custom **From Date** and **To** date. After defining a custom date range, click on the **Or By Date Range** button that can be found on the left side of the **From Date** box (**Figure 3.37**).

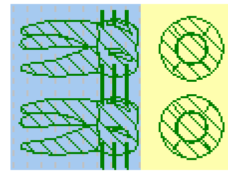
In order to have the odontogram display all of the patient's treatments again, left-click on the **Display All as of Today** button. The odontogram will now show all the treatments performed for this patient regardless of the date of entry (**Figure 3.38**).

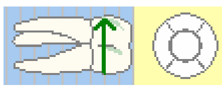
CHARTING LEGEND
- CONDITIONS

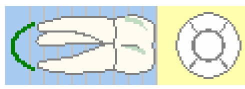

Drifting – Mesial

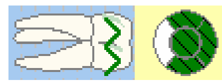

Hypersensitivity

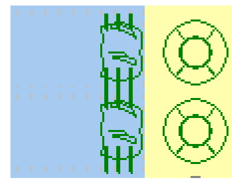

Cracked/Fractured

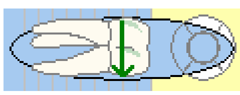

Retainer

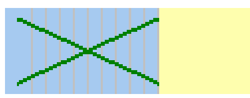

Drifting – Distral

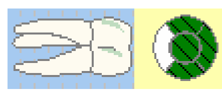

Recession

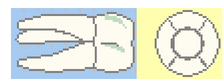

Chip

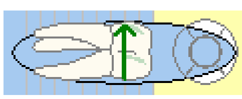

Pontic

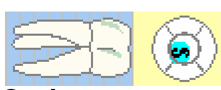

Impacted – Mesial

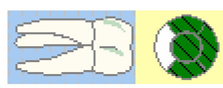

Missing Tooth

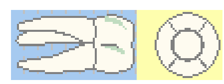

Restorative

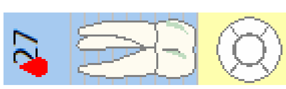

Max. Denture

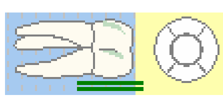

Impacted – Distral

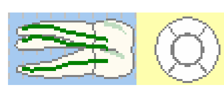

Sealant


Defective Restorative

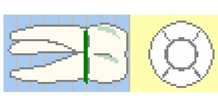

Mand. Denture

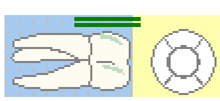

Bleeding

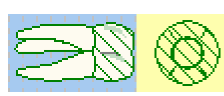

Open Contact - Mesial

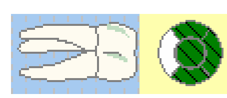

Root Canal

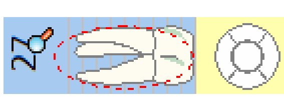

Implant

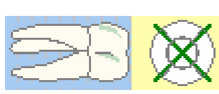

Calculus

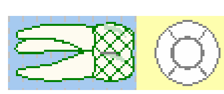

Open Contact - Distral

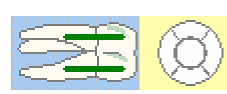

Crown


Carries/Decay


Watch


Nonfunctional Tooth


Veneer


Post

LOGIC TECH CORP

Dedicated to merging technology and dentistry through innovative solutions.

how to contact us

If you are included under a software support contract with Logic Tech, please feel free to call our Technical Support Department whenever you have a question about your Logic Tech computer program.

If you do not have software support contract with Logic Tech, our support services are available to you for a nominal charge. For local calls in the greater Toronto area, please contact us at:

Address.	620 Alden Road, Unit 106 Markham, Ontario L3R 9R7
Office Hours.	Monday to Friday 9:00 AM to 5:30 PM EST Saturday (Support only) 9:00AM to 1:00PM EST
Fax.	905-940-9893
Telephone.	905-946-1477, ext. 303 (Technical Support) 1-800-655-5762, ext. 303 (Technical Support)
Email.	General Information: support@logictechcorp.com Sales Department: sales@logictechcorp.com

to learn more follow us on