EVP EAST VALLEY PERIODONTICS
SCOTT R. PRICE DMD / MS / PC
MORLEY J. SMITH DMD / PC
AARON C. NELSON DMD / MS
DIPLOMATES OF THE AMERICAN BOARD OF PERIODONTOLOGY

Introducing: _____

Phone Number: _____ Date: _____

Reason for Referral:

- ☐ Periodontal Evaluation and Treatment
- ☐ Implant Consultation
  - ☐ Single Implant
  - ☐ Multiple Implants
  - ☐ Implant Supported Denture/ Hybrid
- ☐ Preferred Implant Type
  - ☐ 3i with Encode Abutment
  - ☐ 3i with Standard Abutment
  - ☐ Straumann
- ☐ Extraction/Graft
- ☐ Sinus Augmentation
- ☐ Ridge Augmentation
- ☐ Soft Tissue Grafting
- ☐ Crown Lengthening
- ☐ Canine Exposure
- ☐ Oral Pathology
- ☐ IV Sedation
- ☐ 3rd Molar Extraction
- ☐ Other: _____

Areas of Concern:

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	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Please Email this REFERRAL Slip and most Recent CT Scan, FMX & BWX to:
Date X-Rays were taken: DentalStaff@ EVPERIO.COM

Please complete the entire section below:

Referral Comments:

_____

_____

Planned Restorative Treatment at Your Office:

_____

_____

Referred by Dr: _____ Practice Name: _____

Appointment Date: _____ Time: _____ AM PM