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**PERIODONTICS AND DENTAL IMPLANT SURGERY**

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**Introducing:** \_\_\_\_\_

Reason for Referral:

- |   |   |
|---|---|
| <input type="checkbox"/> Periodontal Evaluation and Treatment | <input type="checkbox"/> Extraction/Socket Preservation |
| <input type="checkbox"/> Comprehensive                        | <input type="checkbox"/> Ridge Augmentation             |
| <input type="checkbox"/> Limited                              | <input type="checkbox"/> Crown Lengthening              |
| <input type="checkbox"/> Implant Consultation                 | <input type="checkbox"/> Soft Tissue Grafting           |
| <input type="checkbox"/> Single Unit                          | <input type="checkbox"/> Oral Pathology                 |
| <input type="checkbox"/> Multiple Units                       | <input type="checkbox"/> IV Sedation                    |
| <input type="checkbox"/> Overdenture                          | <input type="checkbox"/> 3-D Cone Beam CT Scan          |
| <input type="checkbox"/> Immediate Load                       | <input type="checkbox"/> Other _____                    |

Areas of Concern are

|          |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |          |
|----------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----------|
| <b>R</b> | 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 | 16 | <b>L</b> |
|          | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 |          |

Radiographs:

- X-rays need to be taken     \_\_\_\_\_ X-rays given to patient, please return
- X-rays sent via e-mail     \_\_\_\_\_ X-rays given to patient, please keep

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

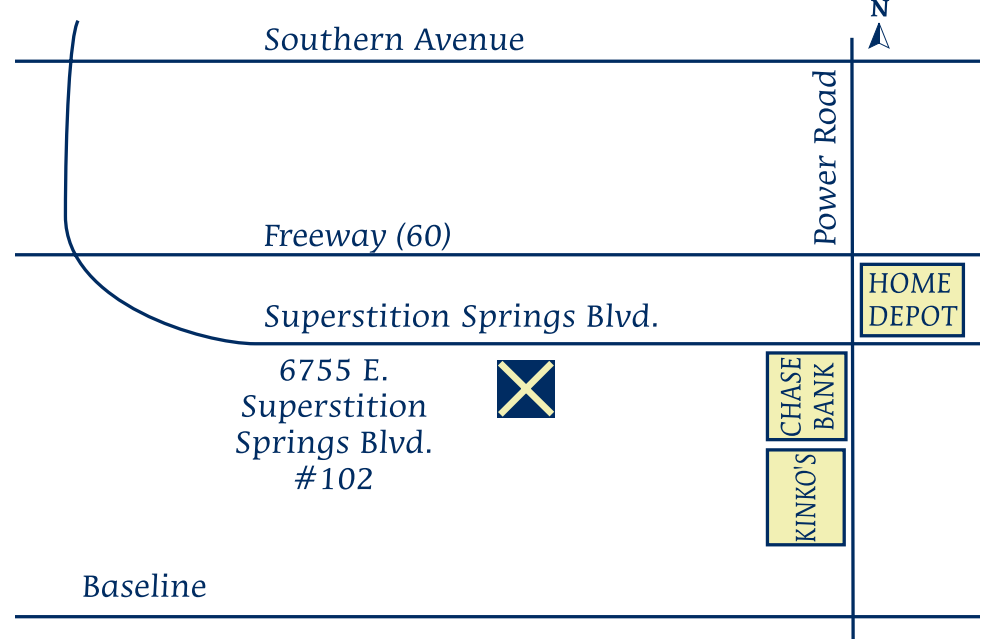
\_\_\_\_\_

\_\_\_\_\_

Referred by Dr. \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Appointment Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_ AM  
 PM

# Superstition Springs Blvd. Office



# Queen Creek Office

