OHIO VALLEY CENTER FOR PERIODONTICS & IMPLANTS

SCOTT SILVERSTEIN, D.D.S., M.S., LLC
MATTHEW M. PARKER, D.D.S., INC.

DIPLOMATES OF THE AMERICAN BOARD OF PERIODONTOLOGY

748 STATE ROUTE 28, SUITE A&B | MILFORD, OHIO 45150 | 513.248.2626
8000 FIVE MILE ROAD, SUITE 350 | CINCINNATI, OHIO 45230 | 513.474.4486
FAX: 513.248.8659 | WWW.LASERGUMS.COM

As our goal is to always accommodate our patients within a timely manner, we ask that the referring doctor contact our office to schedule a time that is at the upmost convenience to the patient being referred. As always, we appreciate the confidence and trust the referring office places in our practice by allowing us the opportunity to help assist in creating beautiful smiles!

Referral Date:_____

This referral form introduces the patient, _____, for a periodontal evaluation with

☐ Dr. Scott Silverstein ☐ Dr. Matthew M. Parker ☐ No Preference

Referred by Dr. _____.

Appointment Scheduled For: _____ _____ _____
Day Date Time

Please provide the following information to our office when scheduling initial appointment.

- ☐ Generalized Periodontal Workup
- ☐ Isolated Periodontal Procedure Required Area: _____
- ☐ Graft Area: _____
- ☐ Frenectomy Area: _____
- ☐ Cuspid Exposure Area: _____
- ☐ Crown Lengthening Area: _____
- ☐ Esthetic Ridge Augmentation Area: _____
- ☐ Abscess Area: Area: _____
- ☐ Implant Consultation: Area: _____
- ☐ Other:_____

Additional Remarks:_____

_____.

Scaling & Root Planing Performed: ☐ Yes ☐ No If yes, please list dates:_____.

Recent X-rays available: ☐ Yes ☐ No If yes, please mark type: ☐ FMX ☐ Panorex ☐ BWX ☐ PA

Date of X-rays referenced: _____.

Please email any available X-rays to *forms@milfordperio.com*

Restorative Treatment Plan (if applicable):

- ☐ Fixed Prosthetics
- ☐ Removeable Prosthetics
- ☐ Other: _____

_____.

*For directions to either of our office locations, please contact our office at 513.248.2626 or email us at **forms@milfordperio.com**.*