Ohio Valley Center for Periodontics & Implants

SCOTT SILVERSTEIN,

D.D.S., M.S., LLC

Board Certified Periodontist
Diplomate of the American Board of Periodontology
Diplomate of the International Congress of Oral Implantologists

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OHIO VALLEY CENTER FOR PERIODONTICS & IMPLANTS
SCOTT SILVERSTEIN, D.D.S., M.S., LLC

Dr. Scott Silverstein

Referral for Periodontal & Dental Implant Care

Referral Date: _____

Patient Name: _____ ***Referring Doctor/Office:*** _____

- ☐ Generalized Periodontal Workup
- ☐ Isolated Periodontal Workup *(tooth #s):* _____
- ☐ Implant Consultation *(tooth #s):* _____
- ☐ Pro Arch/All-On-4 Consultation: **Maxillary | Mandibular | Double**
- ☐ Pinhole Gum Rejuvenation *(tooth #s):* _____
- ☐ Recession/Graft Consultation *(tooth #s):* _____
- ☐ Frenectomy Consultation *(area):* _____
- ☐ Crown Lengthening *(type):* **Esthetic | Functional** *(tooth #s):* _____
- ☐ Cuspid Exposure *(tooth #s):* _____
- ☐ Abscess *(tooth #s):* _____
- ☐ Other *(please explain):* _____

_____.

- ☐ Has Scaling/Root Planing been performed? **Yes | No**

If so, please list dates and area(s) treated: _____

_____.

Are recent x-rays available? **Yes | No**

Type of x-ray(s) available: **FMX | Panorex | PA | BWX | CBCT**

To better serve your patients, please email any available x-rays and/or photographs and images to our office email below: **forms@milfordperio.com**

Additional remarks, comments, or preliminary restorative plan:

_____

_____

_____.

- ☐ This referral is being emailed/faxed so a member of the OVCPI team can reach out to the above referenced patient to schedule their initial appointment.
- ☐ The patient is scheduled for his/her appointment on _____ at _____ AM / PM

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