



Union Oral and Maxillofacial Surgery

REFERRAL FORM

UnionOMS.com

990 RAHWAY AVENUE
UNION, NJ 07083

P: (908) 687-1055
F: (908) 687- 9417

KEVIN J. CORRY, D.D.S.
PERMIT 3618

DATE: _____ PATIENT NAME: _____

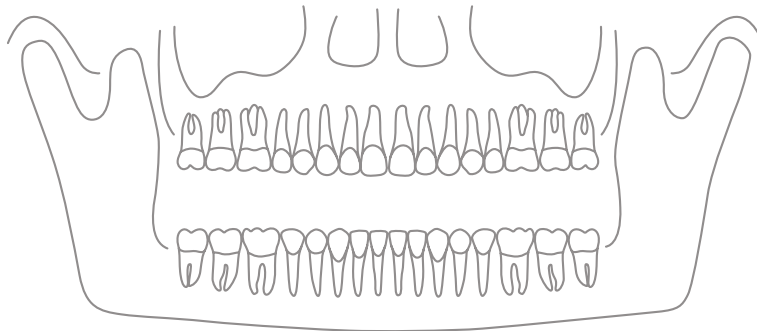
REFERRING DOCTOR: _____

DIAGNOSIS: _____

- Extraction
- Extraction with Bone Preservation
- Biopsy
- Exposure & Bond
- Frenectomy
- Infection
- Apicoectomy

CONSULT:

- Implants
- "All On X" Procedure
- Ridge/Sinus Grafts
- Orthognatic Surgery
- TMJ/TMD
- Oral Pathology



1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
			A	B	C	D	E	F	G	H	I	J			
			T	S	R	Q	P	O	N	M	L	K			
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

R _____ **L**

REMARKS OR SPECIAL INSTRUCTIONS:

SPECIAL INSTRUCTIONS FOR PATIENTS

You have been referred for specialized care to Union Oral and Maxillofacial Surgery. Our office will make every effort to make your visit with us a comfortable experience. Please assist us by providing the following information at the time of your consultation:

- Your surgical referral slip and any x-rays, if applicable,
- A list of medications you are presently taking and the names and phone numbers of your physicians,
- If you have medical or dental insurance, please bring all of your insurance cards with you.



IMPORTANT: All patients under the age of 18 must be accompanied by a parent or legal guardian.

- A pre-operative consultation and physical examination is mandatory for patients undergoing IV anesthesia for surgery,
- Please alert the office if you have a medical condition that may be of concern prior to surgery (i.e. diabetes, high blood pressure, artificial heart valves and joints, blood thinners),
- Our office will be happy to address any concerns you may have about your appointment.



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