



Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Referring Doctor Phone: \_\_\_\_\_

**Reason for Referral**

Extraction       Bone Grafting       Expose/Bracket  
 Implant       All-on-X       Apicoectomy

Pathology

Other: \_\_\_\_\_

Preferred System:  Straumann     Neodent

**Please Mark Teeth or Area to be Treated**

**Referral Comments:**

Right								Left							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
			T	S	R	Q	P	O	N	M	L	K			

**Patient Instructions:**

1. Please call (973) 400-5254 to schedule your consultation appointment.
2. Please bring this referral form, any x-rays, a photo ID, and dental/medical insurance information to your first visit.
3. A legal guardian must accompany anyone under the age of 18.
4. If you anticipate IV anesthesia for your treatment, do not eat or drink for at least 8 hours prior to your appointment. Please arrange for an adult to accompany you and drive you home following treatment.



# MOSAIC

MORRIS ORAL SURGERY  
&  
IMPLANT CENTER

## Time-Saving Tips for our Patients

- ❖ Add our office to your phone contacts instantly by scanning the QR code with your phone camera
- ❖ Pre-register online at [www.morrisoralsurgery.com](http://www.morrisoralsurgery.com)

*We look forward to meeting you and providing you with world-class care in a comfortable, clean, and welcoming environment!*

