

University of Maryland - ASE Implant/Prosthodontic Referral

Return to A. Dudley 650 W. Baltimore St. Rm. #4319 Baltimore, MD 21201

Ph.410-706-8111 Fax410-706-3028

PLEASE PRINT ALL INFORMATION LEGIBLY and include letter of Referral from your Dentist.

Patient Name _____ Male _____ Female _____

Patient Address _____

_____ ZIP _____

Patient SS# _____ Patient DOB _____

Patient Insurance _____ Home Ph# _____

Work Ph# _____ Cell Ph# _____

Parent/Guardian Name if minor _____

Relation to Patient _____

Parent/Guardian SS# _____ & DOB _____

Referring Dentist _____

Ref Dentist Address _____

_____ Zip _____

Dentist's Ph# _____ We accept NO HMO Dental Insurance

Prosthodontic/Implant Assessment by Dentist - Please complete & include referral letter

Diagnosis/Symptoms/Reason for Referral _____

Last Hygiene Maintenance _____ Last BW x-rays _____

Last Full series x-rays _____ Last Panoramic x-ray _____

Patient given the most recent applicable x-rays? – *Pan most helpful for screening* _____

Unless otherwise noted, it is anticipated that the patient will return to the referring dentist after comprehensive treatment needs have been addressed at the Dental School. _____

**Referring Dentist's Signature & Date _____ **

ASE Clinic Use Only: Assigned _____ PR# _____