UNIVERSITY of MARYLAND
SCHOOL OF DENTISTRY

# University of Maryland School of Dentistry

## ASE Endodontic Referral Form – Cash / Commercial Insurance

**Please return this completed form to the Patient Care Coordinator (PCC) with Periapical x-ray**
***650 W. Baltimore St. Room #4319 Baltimore, MD 21201 Phone: 410-706-2860***
***EMAIL referral and PA to: PGENDO@UMaryland.edu***

**Patient Name**_____**Male**_____**Female**_____

**Patient Address** _____

_____**Zip**_____

**Home Phone**_____**Cell Phone**_____

**Patient SS#**_____**Patient Date of Birth** _____

**Best Email for Patient**_____**Patient Insurance** _____

**Ethnicity**_____**Race**_____

**Name of Parent / Guardian if Patient is a Minor**_____

**Relation to Patient**_____**Parent/Guardian SS#** _____

**Parent/Guardian Date of Birth**_____**Best Email for Parent/Guardian** _____

**Name of Referring Dentist**_____**Phone #**_____

**Referring Dentist's Address** _____

_____**Zip**_____

**Will the referring dentist be responsible for the restoration? Yes**_____**No** _____

***The University of Maryland ASE Clinic Does Not Accept Any HMO Dental Insurance***

**Patient's Treatment Needs** ** Information Required for Treatment and Insurance

**** RCT Tooth #** _____**Apical Surgery Tooth #** _____

**Pulpotomy / Pulpectomy Tooth #** _____**Post-space Required?** _____

****Diagnosis and Symptoms** _____

_____
**Referring Dentist signature** **Date**

## *ASE Endodontic Clinic Use Only*

**Tx Letter Sent**_____**Assigned**_____**Pr#**_____