Please return this *form and a written referra*l from your dentist to the Patient Care Coordinator (PCC)
650 W. Baltimore St.   Room #4319   Baltimore, MD 21201   Phone: 410-706-8111
Email: PGReferrals@UMaryland.edu

Dear Doctor, Parent and Patient:

Please complete this form in full and return to the Patient Care Coordinator (PCC), at the address above including:

- **a copy of the front & back of your insurance card and**
- **COPIES of all pertinent x-ray from the dentist (x-rays cannot be returned to you)****

*All requested information and documentation must be submitted to your insurance company by UMSOD for pre-authorization of treatment **PRIOR** to the start of treatment.   **INCOMPLETE REFERRAL PACKETS CANNOT BE PROCESSED** and will be returned to the sender. We appreciate your attention to these directions. Thank you.*

Patient Name_____**Male**_____**Female**_____

Patient Address_____**Zip**_____

Ethnicity_____**Race**_____

Best Daytime Phone_____**Best Email for Patient**_____

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

Patient Insurance _____

Name of Parent / Guardian if Patient is a Minor_____**Relation to Patient**_____

Parent/Guardian SS#   _____**Parent / Guardian Date of Birth** _____

Best Daytime Phone_____**Best Email for Patient**_____

Referring Dentist_____**Phone** _____

Referring Dentist's Address_____**Zip** _____

The University of Maryland ASE Clinic Does Not Accept Any HMO Dental Insurance
Prosthodontic/Implant Assessment by Referring Dentist – Please complete below in ADDITION to a written referral

Diagnosis, Symptoms and Reason for Referral _____

Date of Most Recent Hygiene Maintenance_____**Date of Most Recent BW X-Rays**_____

Date of Most Recent Full Series of X-Rays_____**Date of Most Recent Panoramic X-Ray** _____

****If implant placement, will the referring dentist restore the implants? Yes _____No_____

Referring Dentist's Signature_____**Date** _____

ASE CLINIC USE ONLY: _____**Assigned** _____**PR #** _____