University of Maryland - ASE Endodontic Referral *Cash/Com Insur*

Return to: A. Dudley (w/Periapical x-ray)
650 W. Baltimore St. Rm. #4319 Baltimore, MD 21201 Ph.410-706-8111

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 DDS Address ____

____ **Zip** ______________________

Dentist's Ph# ______________________________ **We accept NO HMO Dental Insurance**

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

- ****RCT Tooth #** __________________________________
- **Apical Surgery Tooth #** __________________________________
- **Pulpotomy/Pulpectomy Tooth #** __________________________________
- **Post-space required?** __________________________________
- **Restorative Treatment Plan** __________________________________
- ****Diagnosis and Symptoms** __________________________________

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ASE Endodontic Clinic Use Only:

Tx Ltr Sent _______________ **Assigned** ___________________________ **PR#** _______________

Endo Ref Form-ad 7-00 Rev 1-28-10