University of Maryland – Faculty Practice Referral Form

Return to FDSP Front Desk 650 W. Baltimore St. Rm. 4th Floor Baltimore, MD 21201 Ph.410-706-7961 Fax410-706-0309

PLEASE PRINT ALL INFORMATION LEGIBLY include letter of Referral if more space needed.

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

Patient Address _____

_____ **ZIP** _____

Patient SS# _____ **Patient DOB** _____

Patient Insurance _____ **Home Ph#** _____

Work Ph# _____ **Cell Ph#** _____ **Preferred #?**

Parent/Guardian Name if minor _____

Relation to Patient _____

Parent/Guardian SS# _____ **& DOB** _____

Referring Dentist _____

Ref Dentist Address _____

_____ Zip _____

Dentist's Ph# _____ **N.B. We accept NO HMO Dental Insurance**

Dental Diagnosis/Symptoms/Reason for Referral _____

_____

_____

Radiographic images available/date? **Last BW's**_____

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

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.

****Ref Dentist's Signature** _____**Date**_____****

FDSP Clinic Use Only: Assigned/Scheduled _____ **PR#** _____