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

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 DDS Address _____

_____ Zip _____

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

Periodontal Assessment - Please print!! **Please complete & include letter of referral !**

Diagnosis, Symptoms and 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 Periodontal Clinic Use Only: Assigned _____ PR# _____