UNIVERSITY of MARYLAND
SCHOOL OF DENTISTRY

University of Maryland School of Dentistry

ASE Periodontics Referral Form – Cash / Commercial Insurance

Please return this *form, the written referral*, copy of your insurance card along with x-rays from your dentist to the Patient CareCoordinator (PCC)

650 W. Baltimore St. Room #4319 Baltimore, MD 21201 Phone 410-706-8111

Email PGReferrals@UMaryland.edu

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

Patient Address_____**Zip**_____

Ethnicity_____**Race**_____

Home Phone_____**Cell Phone**_____

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

Best Email for Patient_____**Patient Insurance** _____

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

Periodontal Assessment *Please include the written referral from the dentist!*

Diagnosis, Symptoms and Reason for Referral _____

_____

Date of Last Hygiene Maintenance_____**Date of last BW X-Rays**_____

Date of Last Full Series of X-Rays_____**Date of Last Panoramic X-Ray** _____

Referring Dentist's Signature_____**Date** _____

ASE Periodontal Clinic Use Only

Assigned_____**PR#** _____