

# Oral and Maxillofacial Pathology

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**CLINICIAN INFORMATION (REQUIRED)**

Clinician Name

Clinician Address

City/State/Zip

NPI #

Clinician Phone

Clinician FAX

Clinician E-Mail

**PATIENT INFORMATION (REQUIRED)- Attach a copy of Patient's or Guarantor's Driver's License/State ID Card**

Patient Name (Last, First, Middle)-full legal name-no nickname

Patient SS#

DOB (M/D/Y)

Race

Patient Address

City

State/Zip

Patient Phone Number

Legal Gender

 M F

Guarantor Name (List person or insured name responsible for bill. (Full legal name, no nickname) Needed for patients under the age of 18yrs.

**SPECIMEN COLLECTION DATE & TIME (REQUIRED)**

Collection Date

Collection Time

**MEDICAL INSURANCE INFORMATION (REQUIRED) Attach a copy of the Medical Insurance Card: Front & Back**

Medical Insurance Company Name

Medical Insurance Company Address

Member ID #

Group #

City

State/Zip

Phone Number

**MEDICARE/MEDICAID INSURANCE INFORMATION (REQUIRED) Attach copy of the Medicare/Medicaid Insurance Card: Front & Back**

Medicare #

Medicaid #

Please bill:  Patient  Insurance  Clinician**CLINICAL INFORMATION (See diagrams on reverse; if lesion involves bone, please enclose radiograph)**

Exact Location of biopsy or surgical site

Duration

Symptoms

Color

Size (cm)

Specimen was:  Excised  Incisionally biopsied  Smear  Aspiration  Other: \_\_\_\_\_

Additional/Pertinent History

Radiograph(s) Enclosed  Yes  No Clinical Photograph(s) Enclosed  Yes  No

Clinical Diagnosis

**LABORATORY USE ONLY****MATERIALS SUBMITTED:****QUANTITY:****FIXATIVE:**

- Blocks \_\_\_\_\_
- Slides (Paraffin) \_\_\_\_\_
- Slides (Frozen Sections) \_\_\_\_\_
- Smear \_\_\_\_\_
- Other \_\_\_\_\_

- Formalin
- Michel's
- None
- Other

Radiograph(s) Received

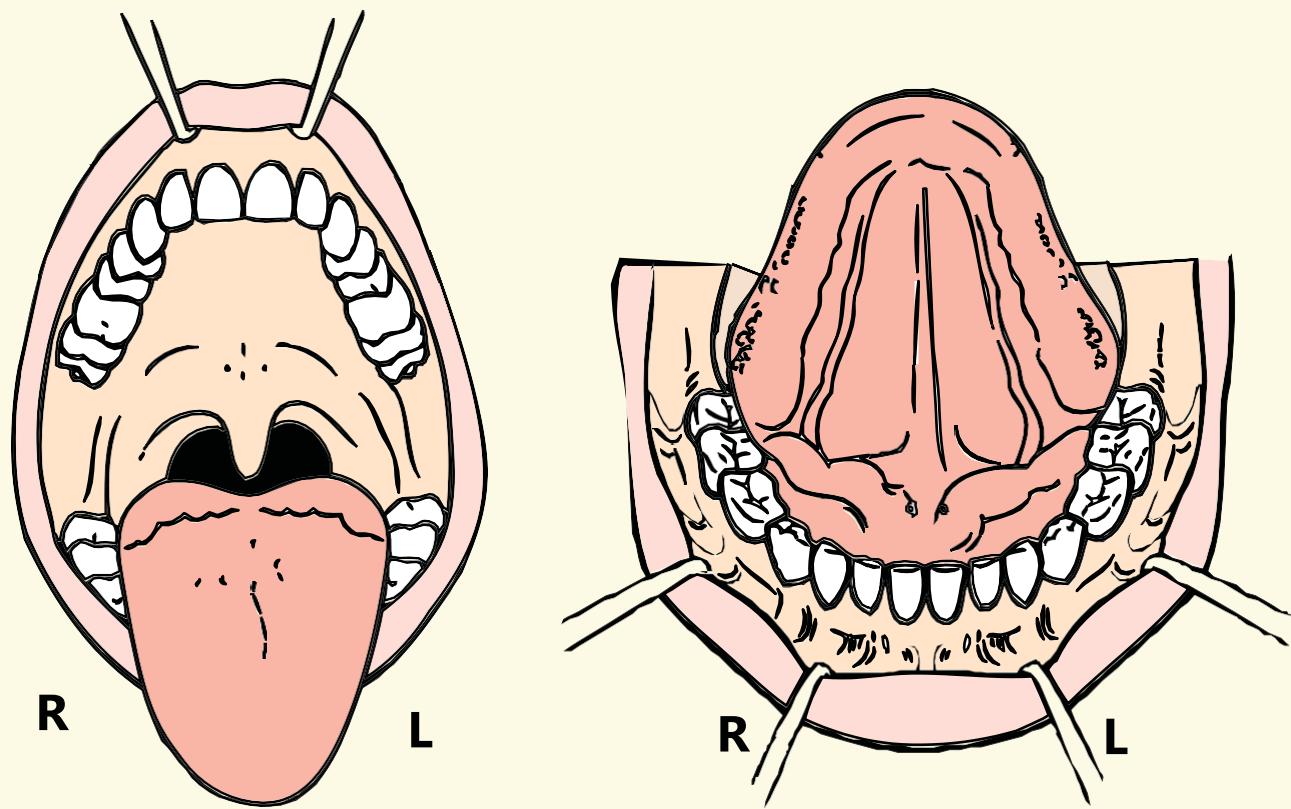
 Yes No

Clinical Photograph(s) Received

 Yes No

Comments:

Mouth



Radiograph

