



LAB USE ONLY:

Accession #:

Date:

Oral and Maxillofacial Pathology

7703 Floyd Curl Drive, MSC 7750
San Antonio, TX 78229-3900**Anne C. Jones, D.D.S.**
Juliana Robledo, D.D.S.Phone: 210-567-6599
FAX: 210-450-2243**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 <input type="checkbox"/> M <input type="checkbox"/> 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
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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 #
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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: <input type="checkbox"/> Excised <input type="checkbox"/> Incisionally biopsied <input type="checkbox"/> Smear <input type="checkbox"/> Aspiration <input type="checkbox"/> Other: _____	
Additional/Pertinent History	
Radiograph(s) Enclosed <input type="checkbox"/> Yes <input type="checkbox"/> No	Clinical Photograph(s) Enclosed <input type="checkbox"/> Yes <input type="checkbox"/> No

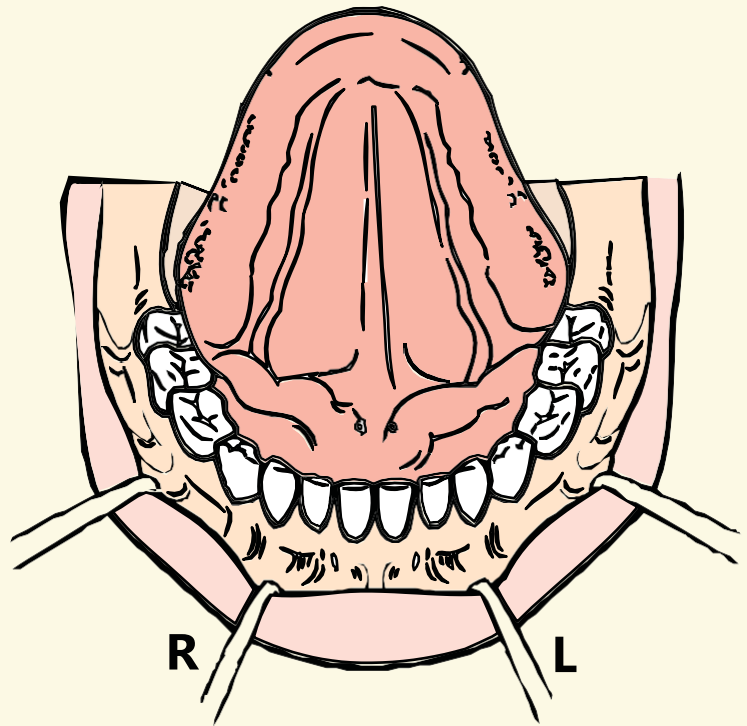
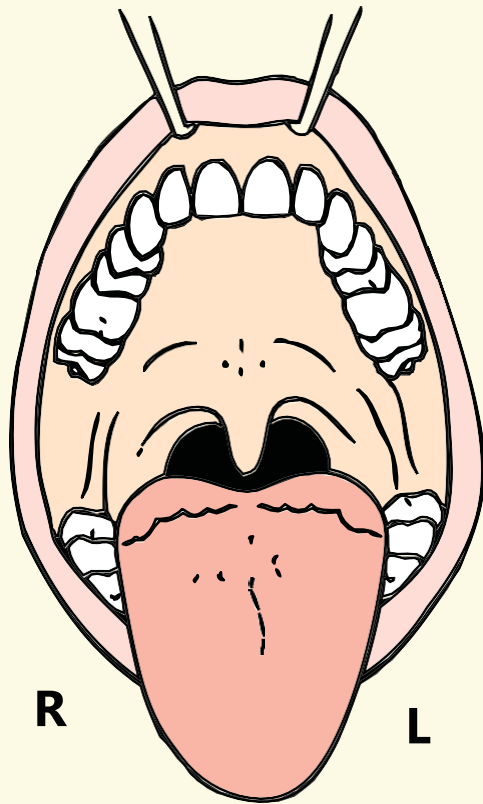
Clinical Diagnosis

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MATERIALS SUBMITTED: <input type="checkbox"/> Blocks <input type="checkbox"/> Slides (Paraffin) <input type="checkbox"/> Slides (Frozen Sections) <input type="checkbox"/> Smear <input type="checkbox"/> Other	QUANTITY: _____ _____ _____ _____ _____	FIXATIVE: <input type="checkbox"/> Formalin <input type="checkbox"/> Michel's <input type="checkbox"/> None <input type="checkbox"/> Other	Radiograph(s) Received <input type="checkbox"/> Yes <input type="checkbox"/> No
			Clinical Photograph(s) Received <input type="checkbox"/> Yes <input type="checkbox"/> No

Comments:

Mouth



Radiograph

