UT Health San Antonio

Oral and Maxillofacial Pathology

LAB USE ONLY:

Accession #:
Date:

7703 Floyd Curl Drive, MSC 7750
San Antonio, TX 78229-3900

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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 ☐ Other: _____

Additional/Pertinent History

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

Clinical Diagnosis

LABORATORY USE ONLY

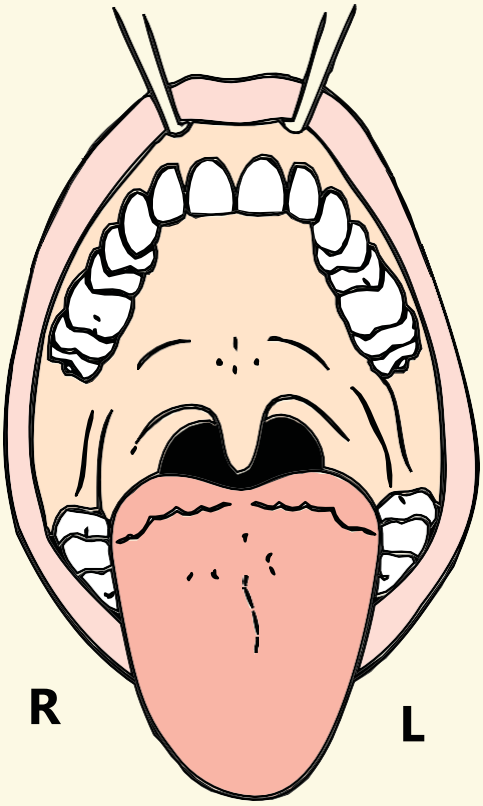
MATERIALS SUBMITTED:	QUANTITY:	FIXATIVE:
☐ Blocks	_____	☐ Formalin
☐ Slides (Paraffin)	_____	☐ Michel's
☐ Slides (Frozen Sections)	_____	☐ None
☐ Smear	_____	☐ Other
☐ Other	_____	

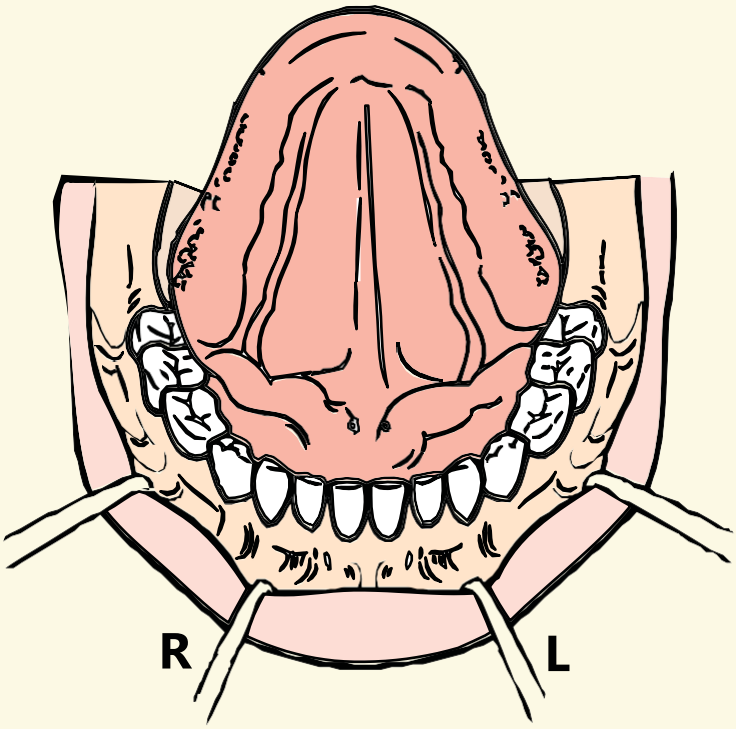
Radiograph(s) Received ☐ Yes ☐ No

Clinical Photograph(s) Received ☐ Yes ☐ No

Comments:

Mouth





Radiograph