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 | |
| Facility Name | |
| Facility 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 | _____ | |

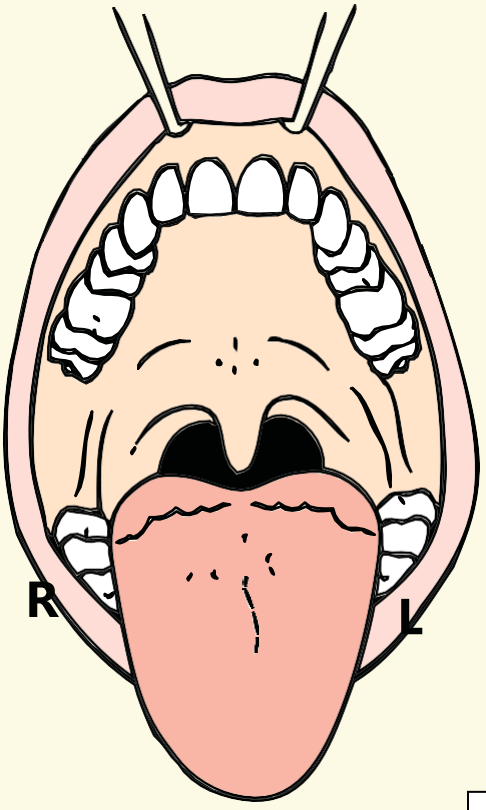
Radiograph(s) Received ☐ Yes ☐ No

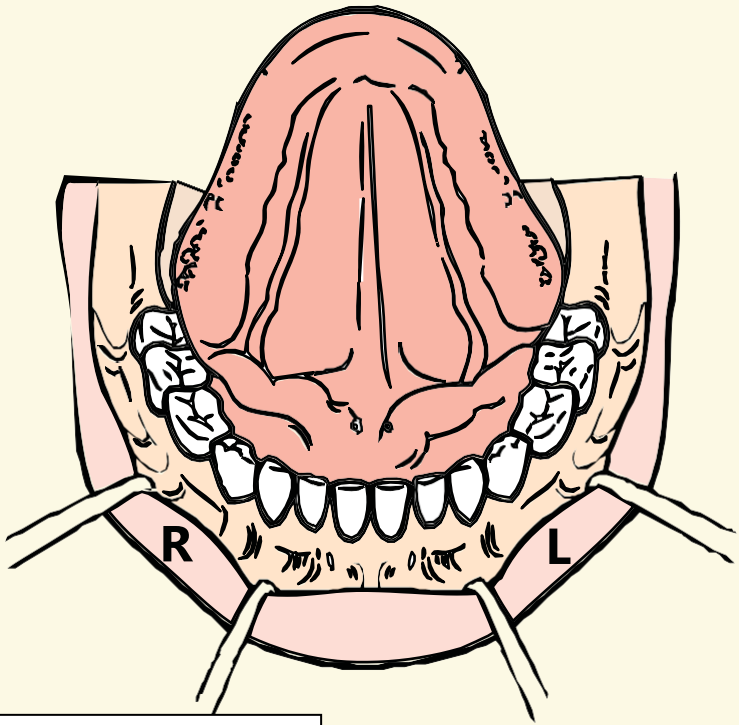
Clinical Photograph(s) Received ☐ Yes ☐ No

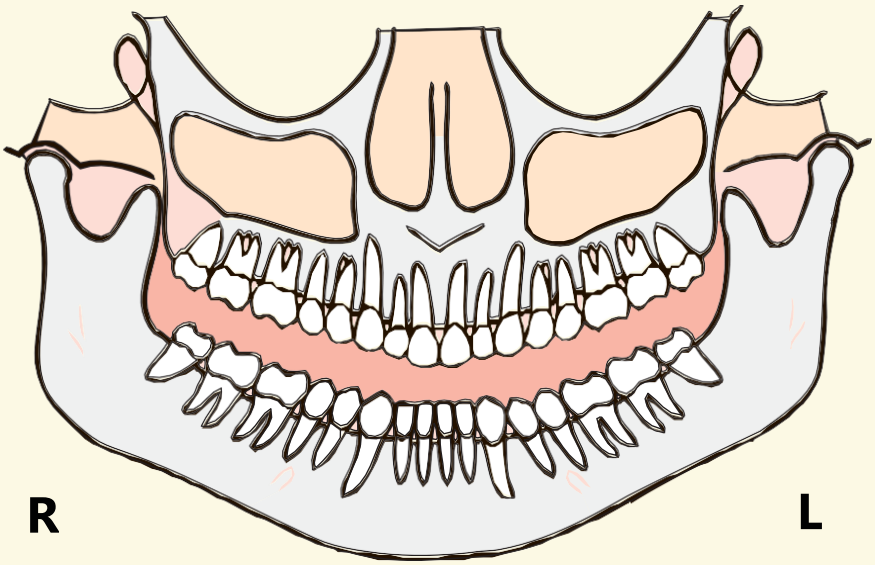
Comments:

Revised 3/18/24

## Mouth




## Radiograph