

PATIENT INFORMATION please print

NAME _____ AGE _____ SEX _____ RACE _____ BIRTHDATE _____ S.S.# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

PATIENT CONSENT SIGNATURE FOR PATHOLOGY ASSESSMENT (Required by HIPAA) X _____

DOCTOR INFORMATION please print

DOCTOR'S NAME _____ FAX REPORT? Y N FAX# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

BILLING INFORMATION check appropriate box

PAYMENT ENCLOSED BILL DENTIST BILL PATIENT OTHER—SEE ATTACHED PATIENT BILLING

CLINICAL DATA → BIOPSY/CYTOLOGY SITE _____ (mark diagram below)

SOFT TISSUE LESIONS

Color _____ Size _____

Duration _____

Swelling Ulceration

Indurated Soft

INTRAOSSEOUS LESIONS

Radiolucent

Mixed

Radiopaque

Expansile

Solid

Cystic

X-ray sent

Duration _____

TYPE OF BIOPSY

Incisional

Excisional

OTHER

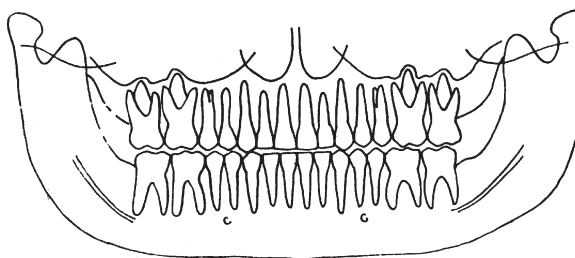
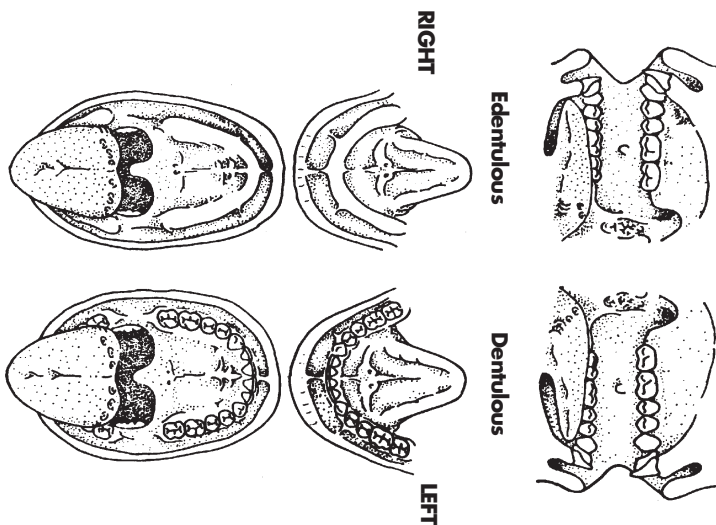
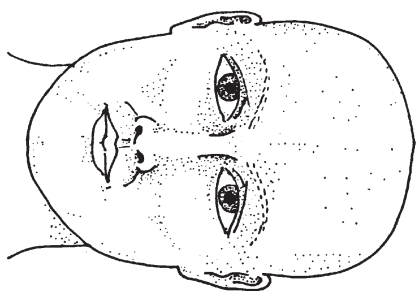
Fungal Smear for Candidiasis

Direct Immunofluorescence (in DIF Transport Medium)

HISTORY _____

CLINICAL IMPRESSION _____

Please send me _____ biopsy mailers. Date of Biopsy _____ Date Received _____



PACIFIC ORAL PATHOLOGY LABORATORY

THIS BOX FOR PATHOLOGY LAB USE ONLY

SOFT TISSUE

HARD TISSUE

R

L

PACIFIC ORAL AND MAXILLOFACIAL PATHOLOGY LABORATORY
BILLING INFORMATION

Patient Name _____

Date of Birth _____

Social Security # _____

Home Telephone () _____

Business Telephone () _____

Patient Relationship to Insured _____

Self Spouse Child Other

PRIMARY MEDICAL/DENTAL INSURANCE CARRIER

Submit copy of card or complete the following:

Insurance Company Name _____

Insurance Company Address _____

Insured's Name _____

Insured's Date of Birth _____

Group # _____ Policy # _____

SECONDARY MEDICAL/DENTAL INSURANCE CARRIER

Submit copy of card or complete the following:

Insurance Company Name _____

Insurance Company Address _____

Insured's Name _____

Insured's Date of Birth _____

Group # _____ Policy # _____

PLEASE REMIT PAYMENT TO "PACIFIC ORAL PATHOLOGY LABORATORY"

Credit Card payment (Check appropriate box)

VISA MASTERCARD NOVUS/DISCOVER

Card # _____

Expiration Date _____

If you have any questions, please call our toll free number **888-582-3397**.

Pacific Oral and Maxillofacial Pathology Laboratory (P.O.M.P.L.)
P. O. Box 10076
Van Nuys, CA 91410-0076

888-582-3397
Tax ID #94-3072353

Dear Patient:

Your dentist is removing tissue from your mouth and submitting it to our laboratory for diagnosis. A complete report of our findings will be made directly to your dentist. If you have any questions about your diagnosis, please contact your dentist.

YOU WILL BE BILLED BY US FOR OUR SERVICE.

The bill for our service is separate from the bill for your surgery.

If you have insurance please complete the reverse side of this page and give it to your dentist's staff so they can enclose it with your biopsy OR if you have an insurance card give that to your dentist's staff so they can copy it and enclose it with your biopsy.

You will be receiving a statement or your insurance company's explanation of benefits in the mail. Any amount not covered by your insurance is your responsibility and is due upon receipt of our statement.

Please mail your payment to our billing office:

Pacific Oral & Maxillofacial Pathology Laboratory
PO Box 10076
Van Nuys, CA 91410-0075

Make check payable to Pacific Oral Pathology Laboratory.

Thank you.