PACIFIC ORAL AND MAXILLOFACIAL PATHOLOGY 155 FIFTH STREET, SAN FRANCISCO, CA 94103

PHONE (415)929-6560 TOLL FREE (866)958-3384 FAX (415)929-6662 DRS. DARREN P. COX AND LETICIA FERREIRA

PATIENT INFORMATION please print

NAME (Last, First) _____ DATE OF BIRTH _____ AGE _____ SEX _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PATIENT SIGNATURE (Required by HIPAA) X _____ PHONE _____

DOCTOR INFORMATION please print

DOCTOR'S NAME _____ PHONE _____ FAX OR EMAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

BILLING INFORMATION check appropriate box

❑ PAYMENT ENCLOSED ❑ BILL PATIENT ❑ OTHER—SEE ATTACHED PATIENT BILLING INFORMATION

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

SOFT TISSUE LESIONS		INTRAOSSEOUS LESIONS		TYPE OF BIOPSY	OTHER
Color _____ *Size* _____		❑ *Radiolucent*	❑ *Mixed*	❑ *Incisional*	❑ *Fungal Smear for Candidiasis*
Duration _____		❑ *Radiopaque*	❑ *Expansile*	❑ *Excisional*	❑ *Direct Immunofluorescence*
❑ *Swelling*	❑ *Ulceration*	❑ *Solid*	❑ *Cystic*		**Clinical and/or radiographic images may**
❑ *Indurated*	❑ *Soft*	❑ *X-ray sent*	*Duration* _____		**be sent electronically to: sf_popl@pacific.edu**

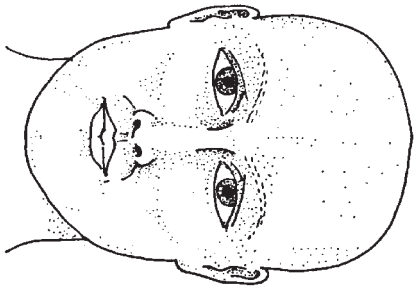
HISTORY _____

CLINICAL IMPRESSION _____

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

IMPORTANT! PLEASE TEAR OFF AND GIVE ATTACHED LETTER / BILLING INFORMATION TO PATIENT AT TIME OF BIOPSY. THANK YOU

PACIFIC ORAL AND MAXILLOFACIAL PATHOLOGY

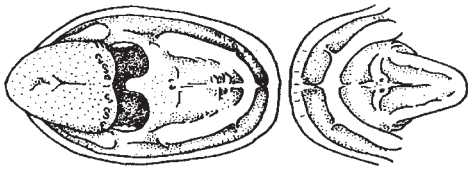


THIS BOX FOR PATHOLOGY LAB USE ONLY

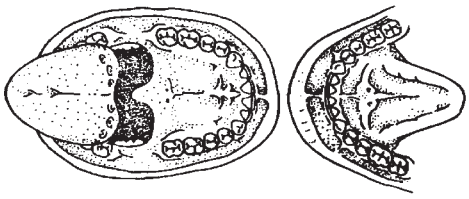
SOFT TISSUE

RIGHT

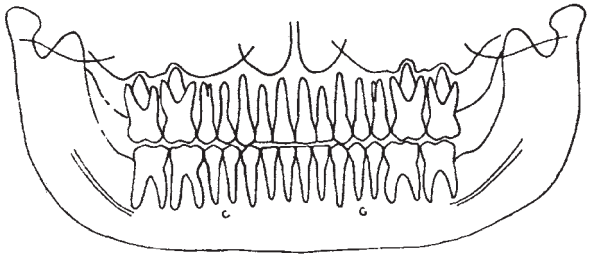
Edentulous



Dentulous



LEFT



R **L**

HARD TISSUE

PACIFIC ORAL AND MAXILLOFACIAL PATHOLOGY
BILLING INFORMATION

Patient Name _____

Date of Birth _____

Social Security # _____

Home Telephone ( ) _____

Business Telephone ( ) _____

Patient Relationship to Insured _____

❑ Self ❑ Spouse ❑ Child ❑ Other

Please complete the information below and return it to your dentist's staff or let them make a copy of your insurance card.

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 folllowing

Insurance Company Name _____

Insurance Company Address _____

Insured's Name _____

Insured's Date of Birth _____

Group # _____ Policy # _____

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

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.

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

Check your payment option box below:

❑ VISA ❑ MASTERCARD ❑ NOVUS/DISCOVER

Card # _____

Expiration Date _____

❑ CHECK

Make checks payable to "Pacific Oral Pathology Laboratory"

Please complete the other side of this sheet and mail it with your payment to:

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

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

Thank you.