❒ Please check if you need additional biopsy bottles.

For lab use only: **PHS**____-____________________
MRN:______________________

SURGICAL PATHOLOGY SUBMISSION FORM

University Dental Health Services (UDHS), Oral and Maxillofacial Pathology Biopsy Service
G-141 Salk Hall, 3501 Terrace Street, Pittsburgh, PA 15261; Send photos and x-rays: pittsburghoralpathology@dental.pitt.edu
Lab: 412-648-8629; Lab Director: 412-648-8635; FAX: 412-383-9142; Billing: 412-624-7800; Clinical Appointments: 412-648-9100

DATE OF SURGERY: ________________________

PATIENT NAME: ____ SOCIAL SECURITY #: ______________________
First Middle Initial Last

PATIENT ADDRESS: ____ PHONE: ( )______________________
____

PATIENT AGE: ___________ BIRTHDATE: _____________________ SEX: ______________ RACE: _____________

REFERRING CLINICIAN: ____ DENTAL LICENSE #: ______________________

CLINICIAN ADDRESS: ____ PHONE: ( )______________________
____ FAX: ( )______________________

RELEVANT CLINICAL HISTORY (symptoms, duration, dental & medical histories, social habits): ______________________________
____
____

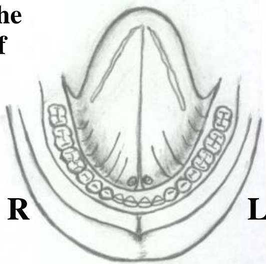
Previous Biopsy: ❒ No ❒ Yes (#____________)

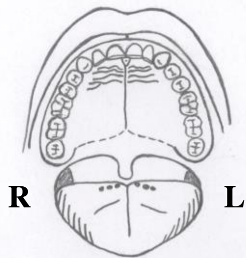
CLINICAL DESCRIPTION (location, size, shape, color, radiographic features): ______________________________________
____
____

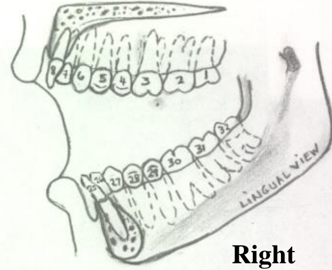
CLINICAL IMPRESSION: ____

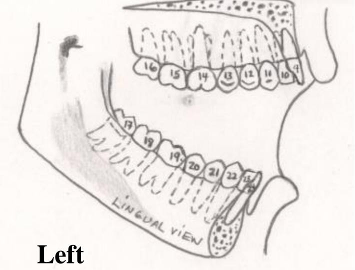
PROCEDURE: ❒ Excisional Biopsy ❒ Incisional Biopsy ❒ Other: ____

Indicate the location of the lesion









<u>MEDICAL INSURANCE INFORMATION</u> **♦Please fill out completely♦ ♦Include a copy of the front and back of the insurance card♦ ♦For HMO, include referral/authorization♦ Note: Incomplete information will delay processing.**

❒ **Self-Insured / No Insurance**
❒ **Medical Insurance Carrier** (BC/BS include plan type)**:**____
Group #:______________________ Policy #:______________________ Medicare #:______________________
Subscriber's Full Name:________________________________ Relationship to Patient: ❒ SELF ❒ SPOUSE ❒ PARENT
Subscriber's Social Security #: ___________________________ Subscriber's Date of Birth: ___________________
Subscriber's Employer and address: ____
Primary Care Provider's Name (for UPMC insurance):___________________________________

<u>WAIVER</u> ♦<u>Must</u> be signed if the patient is self-insured, belongs to a non-participating insurance company, or if incomplete insurance information is provided♦

I understand that my biopsy will be sent to University Dental Health Services, Inc. (UDHS), an outside laboratory, for evaluation and diagnosis. I understand that I am financially responsible for all charges incurred by such service in the event that I do not have medical insurance, my insurance does not cover the service, or that I have not provided adequate information to UDHS. I further authorize the provider(s) to release the information necessary for payment of benefits.

Patient Signature: ____ **Date:** ______________________
Parent Signature (if minor): ____________________________________ **Date:** ______________________

Version: June 23, 2016