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Pathology & Cytology Laboratories, Inc.

PATIENT INFORMATION (PLEASE PRINT)

PATIENT NAME: LAST	**FIRST**	**MI**	CLIENT REF #	**SOCIAL SECURITY NO.**
GENDER □ **M** □ **F**	**DATE OF BIRTH**	**DATE COLLECTED**	**PATIENT RACE**	REQUESTING DDS/DMD/MD
ADDRESS REQUIRED FOR ALL PATIENTS			□ BC/BS □ BGFH □ HUMANA □ AETNA □ UHC KY □ UHC OTHER	
			POLICY ID #	
ADDRESS (INCLUDE APT #)		APT #	GROUP	INSURANCE NAME
CITY	STATE	ZIP CODE	INS. ADDRESS	
TELEPHONE NO. HOME		TELEPHONE NO. ALT	CITY/STATE	ZIP
RESPONSIBLE PARTY/POLICYHOLDER (IF OTHER THAN PATIENT)			□ MEDICARE ID#	
ADDRESS (INCLUDE APT #)			□ MEDICAID ID#	
CITY	STATE	ZIP CODE		

BIOPSY LOCATION:

A:_____

B:_____

C:_____

D:_____

Any associated clinical photographs or radiographic imaging can be sent to oralpath@pandclab.com.

Clinical history and provisional clinical diagnosis:

Mandatory

Signature and Date ⇒

Non-compliance prevents processing of the specimen.

_____ _____

SIGNATURE **DATE**

Clinician's Order for Histopathologic Examination

☐ **Need biopsy bottles and FedEx mailing labels**

SIGNED SURGICAL OP NOTE ALSO REQUIRED