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PATIENT INFORMATION (PLEASE PRINT)				
PATIENT NAME: LAST	FIRST	MI	CLIENT REF #	SOCIAL SECURITY NO.
SEX □ 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 postoperative diagnosis:

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