Date of Biopsy: ______

PLEASE NOTE: Typing of all information is now required. Thank you

P.O. Box 2484
2400 Susannah Street Suite A
Johnson City, TN 37605-2484
Phone: 423.283.4734
Fax: 423.283.4736

SUSAN D. ROLLINS, MD
JANET F. STASTNY, DO
YASMIN ELSHENAWY, MD

Lab. No. ______

Date Rec'd in Lab: ______

Patient's Name ______ LAST ______ FIRST ______ MIDDLE

Address ______ STREET ______ CITY ______ STATE ______ ZIP

Patient Phone ______

Submitted by ______

Date of Birth ___ MO. ___ DAY ___ YR

Sex: ☐ M ☐ F

S.S. # ______

Occupation: ______ ☐☐

Race: ☐ White ☐ Black ☐ Oriental ☐ Other

CLINICAL NATURE OF LESION

☐ Black ☐ Rough ☐ Ulcerated
☐ Blue ☐ Smooth ☐ Bleeding
☐ Brown ☐ Circumsc. ☐ Exudate
☐ Grey ☐ Diffuse ☐ Firm
☐ Pink ☐ Papillary ☐ Soft
☐ Red ☐ Pebbly ☐ Fixed
☐ White ☐ Flat ☐ Moveable
☐ Yellow ☐ Raised ☐ Nodule
☐ Indurated ☐ Vesicle

Size of Lesion in mm:

WAS ASSOCIATED TOOTH VITAL?

☐ Yes ☐ No

SYMPTOMATOLOGY

☐ Painful ☐ Paresthesia
☐ Tender ☐ Asymptomatic

DURATION OF LESION

X-RAY APPEARANCE OF LESION (Please submit films)

☐ Opaque ☐ Circumscribed
☐ Lucent ☐ Diffuse
☐ Mottled
☐ Solitary ☐ Unilocular
☐ Multiple ☐ Multilocular
☐ Root inv. ☐ Expansile

PROVISIONAL CLINICAL DIAGNOSIS

SURGICAL PROCEDURE:

☐ Excision
☐ Incision
☐ Apicoect.
☐ Curettage
☐ Enucleat.
☐ Extract.
☐ ______

LOCATION OF LESION (check box and circle letters)

MAXILLARY MUCOSA

Palate, Hard ☐ L R M
Soft ☐ L R M
Gingiva ☐ L, R; B, L
Ridge ☐ L, R; B, L
M-B Fold ☐ L, R
Tuberosity ☐ L, R; B, L

Maxilla-Central ☐
Sinus inv. ______ L R

Tooth # or area (1-16) ______

MANDIBULAR MUCOSA

Gingiva ☐ L, R; B, L
Ridge ☐ L, R; B, L
Retromolar ☐ L R
M-B Fold ☐ L, R

Mandible-Central ☐
Mand. Can. ______ L R Rms ______ L R

Tooth # or area. (17-32) ______

Tongue:

Dorsum ☐ L R M
Ant. ½ ☐
Post. ½ ☐
Lateral ☐ L R
Ant. ½ ☐
Post. ½ ☐
Ventral ☐ L R M
Ant. ½ ☐
Post. ½ ☐

Floor of Mouth:

Ant. ☐ L R M
Post. ☐ L R

Lip:

Upper ☐ L R M
Lower ☐ L R M

Buccal Mucosa:

Ant. ☐ L R
Post. ☐ L R
Comm. ☐ L R

Fauces ☐ L R

Other Site: ______

Lymph nodes palpable: ☐ Yes ☐ No

Habits:

☐ Cigarettes ☐ Cigars ☐ Pipe
☐ Snuff ☐ Alcohol ☐ Trauma
☐ Chewing ☐ Other ______

Denture: ☐ Upper ☐ Full ☐ Partial
☐ Lower ☐ Full ☐ Partial

Hygiene: ☐ Good ☐ Fair ☐ Poor

***Please have patient sign the payment policy located on the back of form and furnish a copy of insurance card(s).**

Return pathology report to:

Dr. ______

Address ______

City ______ State ______ Zip ______

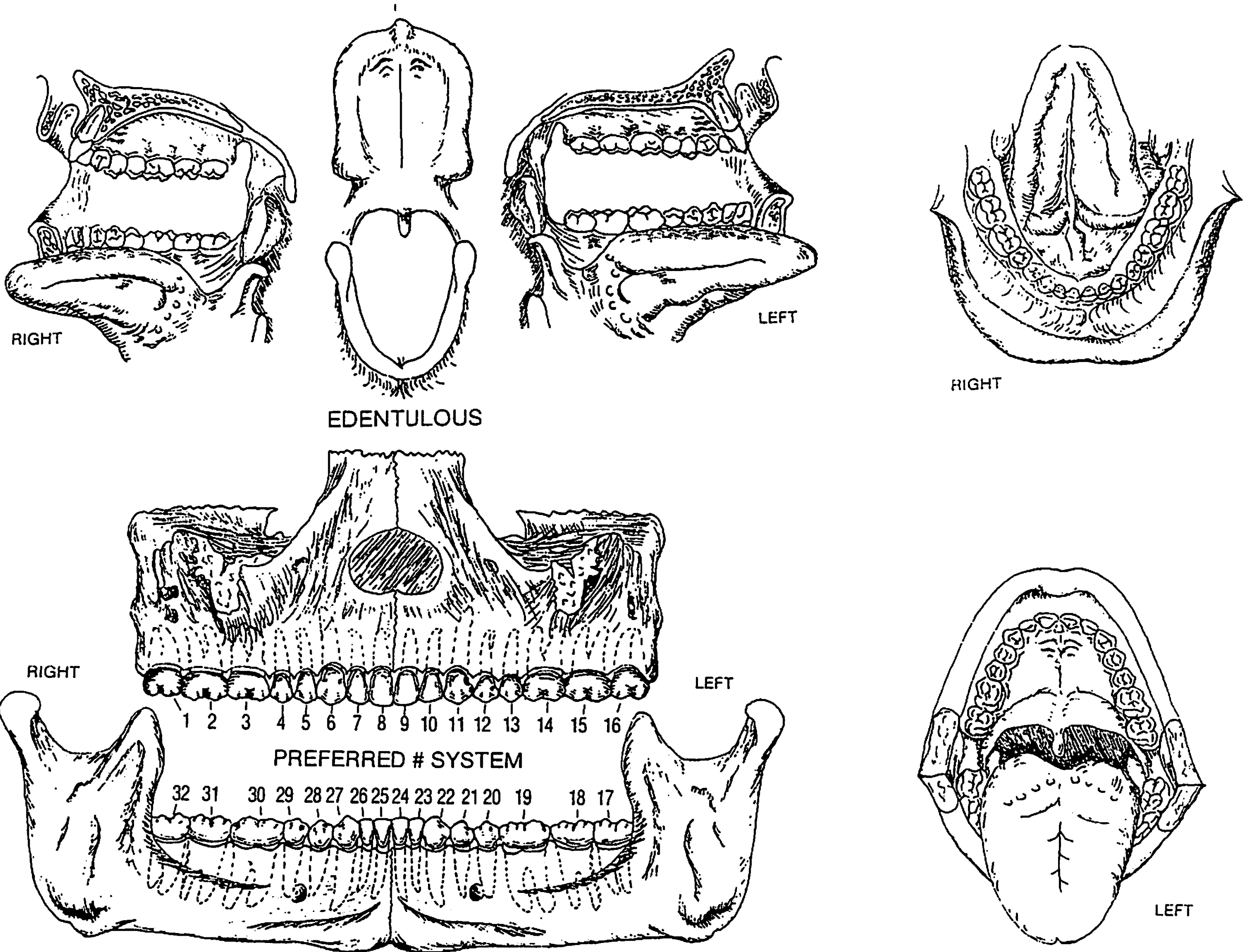
Phone No. ______

Additional history and diagrams are located on the back of this form.

Additional history of case, medical history, and any other pertinent information. ______________________

____

____



Payment Policy

Provider Notice

Medicare will only pay for services that are determined to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare standards, Medicare will deny payment for that service.

Patient Agreement

As a courtesy, the Outpatient Cytopathology Center will file your claim to your insurance company. If you do not have insurance, the Outpatient Cytopathology Center can work with you. Your insurance policy is a contract between you and your insurance company. You are responsible for payment of all services rendered, whether or not your insurance company has paid. It is important to understand that your insurance company may not pay all of the charges and the difference between what they pay and your total charges are your responsibility.

I have read the above payment policy and I understand that I am responsible for payment of my account.

Assignment: I assign and request payment of medical/dental benefits to the rendering physician for services.

Signed: ______________________________ **Date**______________________

Witnessed ____