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

TOLL FREE (866)958-3384 PHONE (415)929-6560 sf_popl@pacific.edu FAX (415)929-6662 DRS. DARREN P. COX AND AUSTIN J. DAVIES

ALL INFORMATION REQUIRED

PATIENT INFORMATION please print

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

ADDRESS _____ APT_____ 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 – PLEASE COMPLETE INSURANCE INFORMATION ON REVERSE

Please send _____ biopsy kits.

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

SOFT TISSUE LESIONS	INTRAOSSEOUS LESIONS		TYPE OF BIOPSY	DISTRIBUTION
Color _____ *Size* _____	❑ *Radiolucent*	❑ *Mixed*	❑ *Incisional*	❑ *Single* ❑ *Multiple* ❑ *Generalized*
Duration _____	❑ *Radiopaque*	❑ *Expansile*	❑ *Excisional*	
❑ *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 _____

DATE OF BIOPSY _____ Date Received _____

Dear Valued Contributor:

So that your patient will understand their responsibility for pathology services, please have them read and initial our statement below.

Your dentist is recommending a biopsy. A biopsy consists of taking all or part of a diseased tissue and sending it to our laboratory for microscopic examination. A complete report of our findings will be sent to your dentist. If you have any questions about your diagnosis, please contact your dentist. We are independent of your dentist's office and therefore the bill is also separate from his/her office. A base fee of $250.00 covers 95% of cases, but may increase if additional tests are required. Your dentist will send your medical and dental insurance information to this laboratory, however, there is no guarantee that your insurance will cover our fees. In that case, you will receive a bill from our laboratory.

Patient's initials: _____ I have read the above statement.

Date: _____

REVISED 2/2025

PACIFIC ORAL AND MAXILLOFACIAL PATHOLOGY
BILLING INFORMATION

Please complete form or send a copy of the insurance card(s) along with the biopsy specimen.

Name _____

Date of Birth _____

Social Security # _____

Home Telephone (_____) _____

Patient Relationship to Insured _____

❑ Self ❑ Spouse ❑ Child ❑ Other

❑ ***PATIENT IS SELF PAY***

MEDICAL 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 # _____

DENTAL INSURANCE CARRIER

Submit copy of card or complete the folllowing

Insurance Company Name _____

Insurance Company Address _____

Insured's Name _____

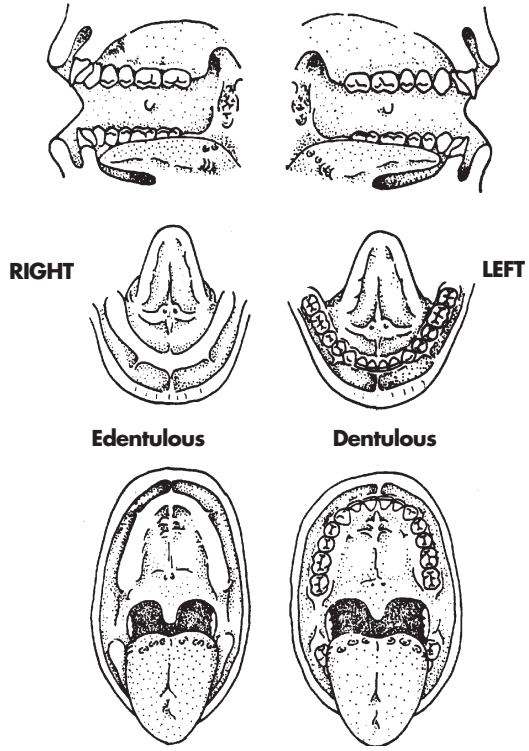
Insured's Date of Birth _____

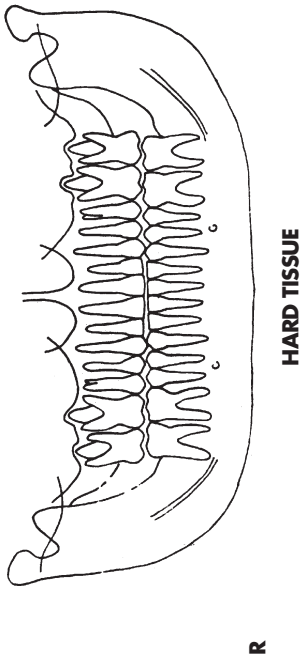
Group # _____ Policy # _____

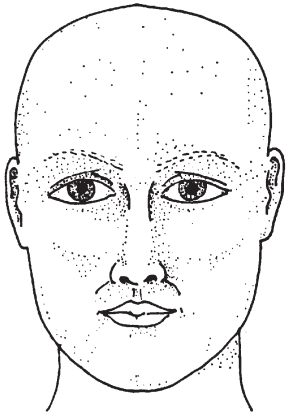
If you have any questions, please call our billing service toll free at **888-582-3397**.

DENOTE BIOPSY LOCATION

SOFT TISSUE







THIS BOX FOR PATHOLOGY LAB USE ONLY

PACIFIC ORAL AND MAXILLOFACIAL PATHOLOGY