



Oral & Maxillofacial Pathology Service

School of Dentistry

Box 35-7133, Seattle, WA 98195-7133

www.dental.washington.edu/oralpath

IMPORTANT NOTICE FOR YOUR PATIENT

**** IMPORTANT ****

The charge for laboratory services is separate from any charges for the services you received today.

WHAT WILL HAPPEN TO MY SPECIMEN TODAY?

Your dentist or oral surgeon will be sending your tissue specimen from today's biopsy to the University of Washington, Oral & Maxillofacial Pathology Service for microscopic examination or laboratory services.

If incomplete or no insurance information is provided by your dentist or oral surgeon's office, you will receive a statement for our charges. ***These lab charges are not included with the services you received today from your dentist or oral surgeon.***

CAN MY INSURANCE BE BILLED?

Yes. Our laboratory services are usually considered a medical benefit, unless the surgery work performed was dental in nature. For example, if the specimen was taken from your teeth or gums it is usually considered a dental procedure. **It is best to provide both your medical and dental insurance information.**

Please note that some HMO plans require a referral for our services. If your plan requires referrals for outside services, please call your primary care medical physician about a referral as soon as possible. Every company's insurance policy is different; please contact your insurance for your plan benefits and coverage.

If you have insurance information with you today, please provide a copy of the front and back of your insurance cards, and ask your dentist or oral surgeon's office to include that information along with your specimen to us.

QUESTIONS?

Local: 206-616-1359

Toll Free: 800-617-8674

Fax: 206-543-8054

Email: omps@u.washington.edu

Website: www.dental.washington.edu/oralpath

Address: Box 35-7133
Seattle, WA 98194-7133

Hours: 8:15 AM - 4:45 PM, Monday - Friday

REQUEST FOR LABORATORY STUDY

UoW 1933 (Rev. 12/06)



Oral & Maxillofacial Pathology Service

School of Dentistry
Box 35-7133, Seattle, WA 98195-7133

PH: 206-543-4440 Email: ompps@u.washington.edu
FX: 206-543-8054 www.dental.washington.edu/oralpath

Medicare No.		LABORATORY USE ONLY
DSHS No. Enclose coupon		
<input type="checkbox"/> Please bill doctor		
<input type="checkbox"/> Please bill patient. Please enclose Front & Back copies of patient's MEDICAL/DENTAL and/or secondary insurance card if you want us to bill the patient's insurance directly.		

Date of Biopsy mo. dy. yr. <input type="checkbox"/> AM <input type="checkbox"/> PM	INSURANCE Name and Address	Subscriber's Name
EMPLOYER'S Name and Address		Subscriber's ID No.
		Subscriber's Date of Birth
		Insurance Group No.

PATIENT INFORMATION — PLEASE TYPE OR PRINT CLEARLY

Patient's Name (Last) (First) (M.I.)	Birthdate	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race
If Minor, Parent or Guardian Name			Social Security No.*
Patient's Address (Number & Street)	(Apt. #)	Home Phone	
(City)	(State)	(ZIP)	Work Phone

PERFORMING DOCTOR INFORMATION

Doctor's Name	Email and/or Website	NPI No.
Doctor's Address (Number & Street)	(Suite #)	Phone
(City)	(State)	(ZIP)
		Fax No.

MEDICAL INFORMATION — Description of Lesion (Please use diagrams on reverse side)

Location	
Duration	
Size	
Color	
Symptoms	
Associated Findings and Past History	Previous Biopsy Accession No.

Smoking and Alcohol Use (optional)			
Has the patient ever used tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of years _____	Current use? <input type="checkbox"/> Yes <input type="checkbox"/> No	What type? <input type="checkbox"/> Cigarette <input type="checkbox"/> Pipe/Cigar <input type="checkbox"/> Smokeless <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Other _____
			Mouthwash (brand) _____
			Toothpaste (brand) _____

PROCEDURE AND RESULTS

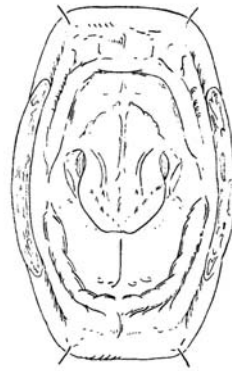
Radiographic Findings	<input type="checkbox"/> Radiographs Enclosed <input type="checkbox"/> Radiographs Sent Separately <input type="checkbox"/> Photograph Enclosed
Clinical Impression	
Type of Biopsy <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional <input type="checkbox"/> Curettage <input type="checkbox"/> Laser <input type="checkbox"/> Other (specify) _____	

*The Oral and Maxillofacial Pathology Service has requested your Social Security Number because it serves as a unique identifier. Disclosure of the number is voluntary and no statute or rule specifically directs the Service to request the number. If you decline to provide the number, the Service shall not for that reason deny diagnostic services.

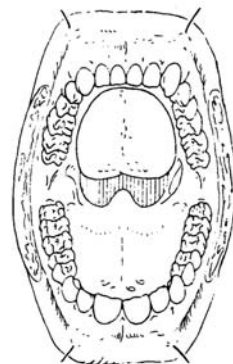
Performing Doctor's Signature

Date

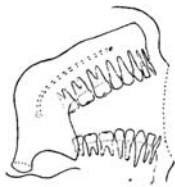
EDENTULOUS



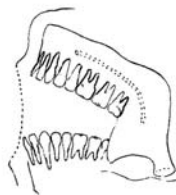
NORMAL



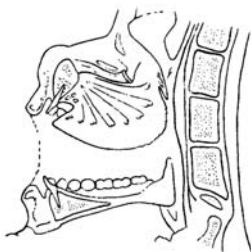
LEFT



RIGHT



LEFT



RIGHT

