

**PACIFIC ORAL AND MAXILLOFACIAL PATHOLOGY LABORATORY  
BILLING INFORMATION**

Patient Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 Home Telephone ( ) \_\_\_\_\_  
 Business Telephone ( ) \_\_\_\_\_  
 Patient Relationship to Insured \_\_\_\_\_  
 Self     Spouse     Child     Other

**PRIMARY MEDICAL/DENTAL 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 # \_\_\_\_\_

**SECONDARY MEDICAL/DENTAL 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 # \_\_\_\_\_

Credit Card payment (Check appropriate box)

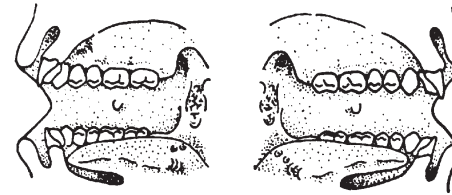
PLEASE REMIT PAYMENT TO "PACIFIC ORAL PATHOLOGY LABORATORY"

VISA     MASTERCARD     NOVUS/DISCOVER

Card # \_\_\_\_\_  
 Expiration Date \_\_\_\_\_

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

**SOFT TISSUE**

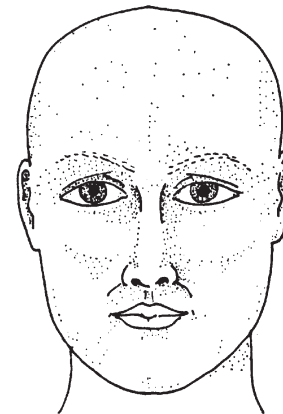
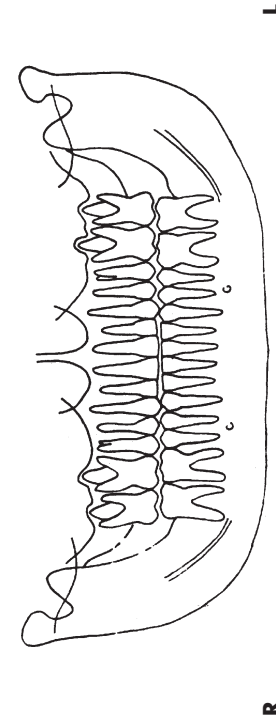
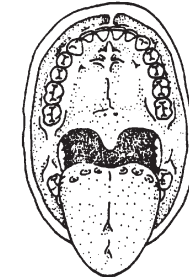
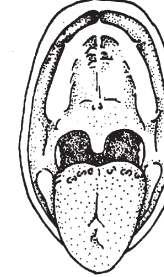
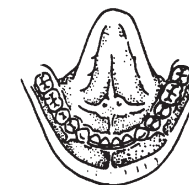


**Edentulous**

**Dentulous**

**RIGHT**

**LEFT**



THIS BOX FOR PATHOLOGY LAB USE ONLY

**PACIFIC ORAL AND MAXILLOFACIAL PATHOLOGY LABORATORY 2155 WEBSTER ST., ROOM 408, SAN FRANCISCO, CA 94115**

PHONE (415)929-6560 TOLL FREE (866)958-3384 FAX (415)929-6662 DRs. W.M. CARPENTER, N. SAID AND P.W. MERRELL

**PATIENT INFORMATION** please print

NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ RACE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ S.S.# \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

PATIENT CONSENT SIGNATURE FOR PATHOLOGY ASSESSMENT (Required by HIPAA) X

**DOCTOR INFORMATION** please print

DOCTOR'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_ FAX REPORT  YES  NO FAX# \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**BILLING INFORMATION** check appropriate box

PAYMENT ENCLOSED  BILL DENTIST  BILL PATIENT  OTHER—SEE ATTACHED PATIENT BILLING

**CLINICAL DATA** → BIOPSY/CYTOLOGY SITE \_\_\_\_\_ (mark diagram on reverse) →

SOFT TISSUE LESIONS

Color \_\_\_\_\_ Size \_\_\_\_\_  
Duration \_\_\_\_\_  
 Swelling  Ulceration  Soft  
 Indurated  Sore

INTRACOSSEOUS LESIONS

Radiolucent  Mixed  Incisional  Fungal Smear for Candidiasis  
 Radiopaque  Expansile  Excisional  
 Solid  Cystic  Direct Immunofluorescence  
 X-ray sent Duration \_\_\_\_\_ (in DIF Transport Medium)

TYPE OF BIOPSY

Incisional  Fungal Smear for Candidiasis  
 Excisional  Direct Immunofluorescence  
(in DIF Transport Medium)

**HISTORY** \_\_\_\_\_

**CLINICAL IMPRESSION** \_\_\_\_\_

Please send me \_\_\_\_\_ biopsy mailers. Date of Biopsy \_\_\_\_\_ Date Received \_\_\_\_\_

**IMPORTANT! PLEASE TEAR OFF AND GIVE ATTACHED LETTER / BILLING INFORMATION TO PATIENT AT TIME OF BIOPSY. THANK YOU**

..... Line is to show perf. DO NOT PRINT

**Pacific Oral and Maxillofacial Pathology Laboratory (P.O.M.P.L.)  
P. O. Box 10076  
Van Nuys, CA 91410-0076**

**888-582-3397  
Tax ID #94-3072353**

Dear Patient:

Your dentist is removing tissue from your mouth and submitting it to our laboratory for diagnosis. A complete report of our findings will be made directly to your dentist. If you have any questions about your diagnosis, please contact your dentist.

YOU WILL BE BILLED BY US FOR OUR SERVICE.  
The bill for our service is separate from the bill for your surgery.

If you have insurance please complete the reverse side of this page and give it to your dentist's staff so they can enclose it with your biopsy OR if you have an insurance card give that to your dentist's staff so they can copy it and enclose it with your biopsy.

You will be receiving a statement or your insurance company's explanation of benefits in the mail. Any amount not covered by your insurance is your responsibility and is due upon receipt of our statement.

Please mail your payment to our billing office:

Pacific Oral & Maxillofacial Pathology Laboratory  
PO Box 10076  
Van Nuys, CA 91410-0075

**Make check payable to Pacific Oral Pathology Laboratory.**

Thank you.