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 **Steven D. Budnick, DDS**

 **Medical Director**

ORAL and MAXILLOFACIAL PATHOLOGY

OTOLARYNGOLOGIC PATHOLOGY

TEST REQUEST FORM

**REQUIRED PATIENT INFORMATION REQUIRED DOCTOR INFORMATION**

**PATIENT NAME:** *(please print last, first, middle)* **SUBMITTING DOCTOR NAME:** *(please print)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_**AGE:** \_\_\_\_\_\_ **SEX:** □ **M** □ **F** **INSTITUTION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOCTOR ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CITY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**STATE:** \_\_\_\_\_\_ **ZIP:** \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SUITE/ROOM:** \_\_\_\_\_\_\_\_\_\_\_

**PHONE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FAX:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CITY:** \_\_\_\_\_\_\_\_\_\_\_**STATE:** \_\_\_\_\_\_ **ZIP:** \_\_\_\_\_\_\_\_\_\_

**Patient insurance information MUST be completed PHONE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FAX:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**for ANY/ALL insurance to be filed. Attach a copy of**

**insurance card (including Medicare and Medicaid.) UPIN/PROVIDER#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICARE# \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Client authorization or person legally responsible for** **bill, if other than patient.)**

**MEDICAID# \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **RESPONSIBLE PARTY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE COMPANY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POLICY#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **CITY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**STATE:** \_\_\_\_\_\_ **ZIP:** \_\_\_\_\_\_

**GROUP#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **RELATIONSHIP: □SELF** □**SPOUSE** □ **DEPENDENT**

**ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **LAB DATA:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CITY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**STATE:** \_\_\_\_\_\_ **ZIP:** \_\_\_\_\_\_

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**PHONE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FAX:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ATTENTION:** **All material submitted (slides, containers etc.) must be labeled with patient name and second identifier accompanied by requisition. When ordering tests in which Medicare reimbursement will be sought, physicians should ONLY order tests which are medically necessary for diagnosis or treatment.**

**To meet Federal Compliance Standards, ICD-9 code must be included: ICD-9 CODE: 1.** \_\_\_\_\_\_\_\_ **2.** \_\_\_\_\_\_\_

**DATE SPECIMEN TAKEN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **SPECIMEN TYPE: □ INCISIONAL BIOBSY**

**SIZE OF LESION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LOCATION: \_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLINICAL HISTORY: \_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **□ EXCISIONAL BIOPSY**

 **CLINICAL DIAGNOSIS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RADIOGRAPH SENT:** \_\_\_\_\_\_ **PHOTO SENT:** \_\_\_\_\_\_