PATHOLOGY DEMOGRAPHIC FORM

Carl M. Allen, DDS, MSD
Ashleigh Briody, DDS, MS
Oral And Maxillofacial Pathology

Ohio ENT & Allergy Physicians
477 Cooper Road, Suite 480, Westerville, OH 43081
Phone: (614) 586-4254; **Fax**: (614) 255-7690

PLEASE COMPLETE THE FORM AND INCLUDE A COPY OF THE FRONT AND BACK OF THE PATIENT'S INSURANCE CARD. THANK YOU!

Required Patient Information (please print):

Patient Name: _____
Address: _____
Male: _____ Female: _____
Email address: _____

Date of Birth: _____
City, State, Zip: _____
Phone Number: _____
SSN: _____

Primary Medical Insurance Information:

Insurance Company: _____
Policy #: _____ Group #: _____
Policy Holder: ▢ Patient ▢Other: _____
If patient then skip, if other please complete:
Relationship: _____
SSN: _____ DOB: _____

Secondary Medical Insurance Information:

Insurance Company: _____
Policy #: _____ Group #: _____
Policy Holder: ▢ Patient ▢Other: _____
If patient then skip, if other please complete:
Relationship: _____
SSN: _____ DOB: _____

Guarantor Information (Financially Responsible Party, if different from above):

Name & Relationship: _____
Address: _____
City, State, Zip: _____ Phone #: _____

Required Doctor Information:

Submitting Doctor Name: _____
Address, City, State, Zip: _____
Phone #: _____ Fax #: _____

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

For Lab Use Only:

Date received: _____ Accession Number: _____ MRN: _____

For office use only: MRN _____

CONSENT FORM

OHIO ENT & ALLERGY ORAL AND MAXILLOFACIAL PATHOLOGY
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Your doctor has determined that you need to have a biopsy procedure performed. The tissue removed during today's surgery will be sent to Dr. Carl Allen or Dr. Ashleigh Briody, oral and maxillofacial pathologists at Ohio ENT and Allergy Physicians, Inc., for microscopic examination and diagnosis. Our board-certified Oral and Maxillofacial Pathologists will send a written report of the test results to your doctor. Your doctor will discuss the test results with you.

You will receive a bill directly from Ohio ENT and Allergy Physicians, Inc. for this service, which is separate from the fee charged by your surgeon. Based upon the different complexities of each tissue sample we receive, our fees may vary. In case of multiple tissue sites, each site will have a separate fee. Decalcification of hard tissue and special studies take additional time and entail additional charges.

As a courtesy to you, we can bill your medical insurance company for reimbursement for our services. We need the following information to help process your medical insurance claim:

1. **A legible copy of the front and back of your medical insurance card.**
2. **Full name of the patient, date of birth, phone number, and address.**
3. **If the patient is a child or dependent, we need the guardian's full name, date of birth, and address.**

ASSIGNMENTS OF BENEFITS:
I acknowledge financial responsibility for all facility and physician/provider(s) fees. I understand that the physician billing office will file my insurance claim and I assign direct payment to the physician all payments made under the terms and provisions of my policy. I further understand that any disputes on coverage are between my insurance carrier and myself and I will be responsible for payment for denied services regardless of the outcome of my dispute. I acknowledge financial responsibility for all charges if inaccurate insurance information is given at time of service and the information is not corrected prior to my insurance company's timely filing limit.

If your medical insurance is not listed on our list of participating insurance companies or if you are not insured, prepayment is required. Our basic pathology fee is $150. If decalcification or special studies are needed, those will be billed to you separately. Please enclose payment. Checks may be payable to Ohio ENT & Allergy Physicians.

I authorize release of information pertaining to the claim filed with my insurance company for the services provided by Ohio ENT and Allergy Physicians, Inc. I understand that I am responsible for the prompt payment for these services.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Printed Name of Patient or Legal Guardian

For office use only: MRN _____

BIOPSY REQUISITION FORM

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Patient Name: _____ DOB: _____ M/F/U: _____

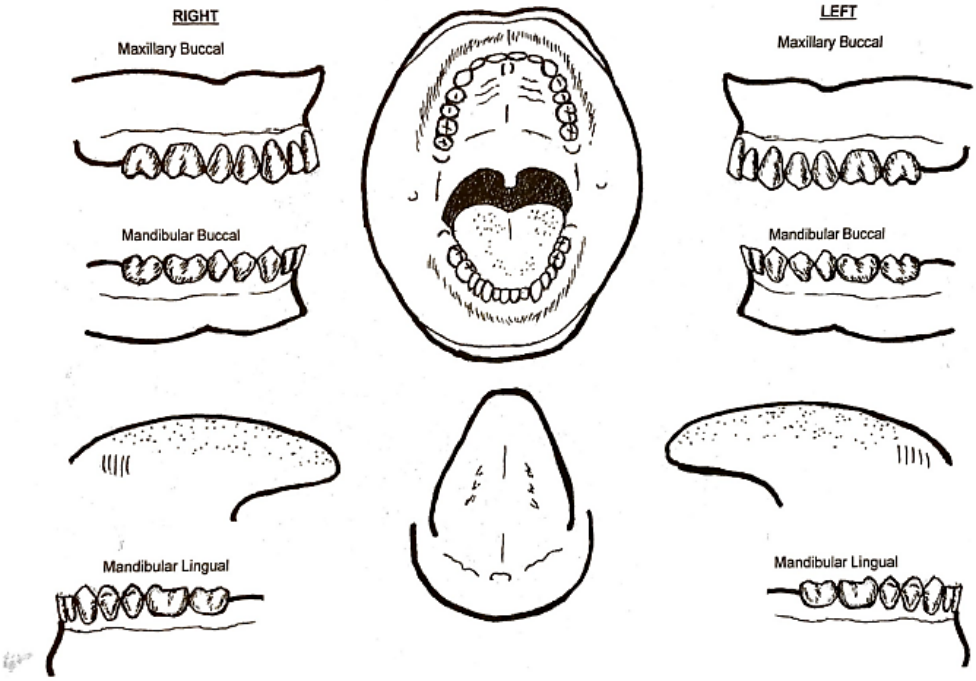
COLOR
___NORMAL
___ WHITE
___ RED
___ BLUE
___ BROWN

SHAPE
___ PEDUNCULATED
___ SESSILE
___ FLAT
___ ULCERATED

CONSISTENCY
___ FIRM
___ SOFT
___ FLUCTUANT
___ PULSATILE

TEXTURE
___ SMOOTH
___ GRANULAR/ROUGH
___ PAPILLARY

RADIOGRAPHIC FINDINGS
___ RADIOLUCENT ___ EXPANSILE ___ RADIOPAQUE
___ NON-EXPANSILE ___ MIXED ___ WELL-DEFINED
___ POORLY DEFINED ___ UNILOCULAR ___ MULTILOCULAR



ANATOMIC LOCATION:

SIZE:

PERTINENT MEDICAL HISTORY:

PROCEDURE:
EXCISIONAL BIOPSY
INCISIONAL BIOPSY
CYTOLOGY
EXCISIONAL BIOPSY, CURETTAGE

OPERATIVE FINDINGS:

WORKING DIAGNOSIS:

Additional Materials Sent (circle): Radiographs: YES / NO ; Photographs: YES / NO

Doctor's Signature: _____

Biopsy Date: _____

For office use only: MRN _____