Oral Pathology Services

3200 South University Drive. 3rd Floor, Room 7393
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Oral and Maxillofacial Pathology Outside Patient Requisition

E-mail: oralpath@nova.edu

PATIENT INFORMATION

Last Name	First Name	M.I.

Street Address	Apt #

City	State	ZipCode

Patient Phone Numbers	Work	Home

Date of Birth	Age	Sex	Race	Social Security

SUBMITTING DOCTOR INFORMATION

Name	

Address	

Phone	Fax

Supplies needed ❑ Phone Report ❑
Fax Report ❑

NPI#

GUARDIAN INFORMATION *(please fill if patient is under 18)*

Last Name	First Name	DOB

BILLING (ATTACH COPY OF MEDICARE CARDS)

Patients must review and sign informed consent for treatment and release of information form

BILL

❑ Patient
❑ Medicare
❑ Physician

Medicare Patient:

☐ Medicare is Primary Insurance
☐ Medicare is Secondary Insurance
Primary Insurance is:

Medicare #: _____ Medigap: _____

Doctor Signature:

Date of Biopsy [ ][ ][ ] ❑ Excisional ❑ Incisional

X-RAY included ❑ Yes ❑ No **X-Rays must be included for all bone lesions**

Description of lesion (include duration, symptoms, color, consistency):

_____

_____

_____

CLINICAL DIAGNOSIS

_____

_____

SPECIMEN SUBMITTED	EXACT LOCATION	SIZE
A		
B		
C		

Medical History

Lab Use Only

WHITE AND PINK COPY
SUBMIT TO NSU WITH SPECIMEN

YELLOW COPY
DOCTORS COPY