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OPDS Oral Pathology Diagnostic Services

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www.opds.net

LAB USE ONLY
ACCESSION NO. OP-
DATE RECEIVED

BIOPSY REQUEST

Must be printed for Doctor and Patient signatures

DOCTOR INFORMATION

DOCTOR NAME	REPORT TO BE SENT VIA ☐ FAX ☐ EMAIL	
ADDRESS	PHONE NO. ( )	FAX NO. ( )
CITY, STATE, ZIP CODE	WEBSITE URL	
X DOCTOR'S SIGNATURE	EMAIL ADDRESS	

PATIENT INFORMATION

PATIENT NAME -- LAST	FIRST	M.I.	SEX	DATE OF BIRTH
ADDRESS -- STREET	EMAIL			
CITY, STATE, ZIP CODE	PHONE NO. WITH AREA CODE ( )	RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)		

TEST INFORMATION MUST BE COMPLETE!

BIOPSY DATE: ▶	MO.	DAY	YR.	☐ IMAGES EMAILED	BIOPSY TYPE ☐ EXCISIONAL ☐ INCISIONAL ☐ CURETTAGE ☐ OTHER (specify):	SEND EXTRA BIOPSY CONTAINERS ☐ Number: _____

SPECIMEN INFORMATION

BIOPSY SITE(S): _____

PERTINENT HISTORY: _____

_____

_____

_____

CLINICAL APPEARANCE: _____

_____

RADIOGRAPHIC APPEARANCE: _____

(PLEASE SUBMIT IMAGES ON BONY LESIONS)

CLINICAL IMPRESSIONS & COMMENTS _____

PLEASE HAVE PATIENT READ & SIGN

We are not contracted with any Third Party Payors. Oral Pathology Diagnostic Services has opted out of Medicare. I, the undersigned, agree and acknowledge the following: To pay the provider the full fee for the service(s) provided; Not to submit a claim to Medicare; Acknowledge that supplemental insurance may not make payment because Medicare will not make payment; Acknowledge that I (the patient) can choose to go to another provider that is contracted with Medicare. We are not providers of any insurance companies. You will be responsible for our full fee. Any reimbursement from your insurance company will be sent directly to you.

PATIENT CONSENT FOR PATHOLOGIC ASSESSMENT.
I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL SERVICES.

X

PATIENT / LEGAL GUARDIAN SIGNATURE (REQUIRED)