Accession No.: S- _____ Date Received:_____

Surgical Oral Pathology Request

Department of Oral Pathology, Radiology and Medicine
The University of Iowa – College of Dentistry – Iowa City, Iowa 52242-1001
Telephone: (319) 335-9656 Fax: (319) 335-7351

Part A – Patient Information

Patient Name _____ _____ _____
Last First Initial

Address _____

City _____State_____ Zip_____

SSN _____ Date of Birth _____ Sex ____

Phone Number __(_____)_____

Part B – Provider Information

Practitioner Name _____

Office Name _____

Address _____

_____

Phone _____ Fax _____

For all patients under age 18: Guarantor's Name_____ Guarantor's DOB:_____

Part C – Clinical Data

Date of Biopsy:

Summary of Clinical Findings:

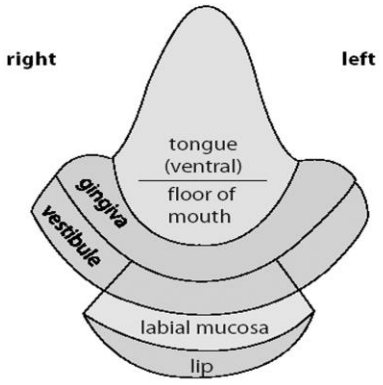
Radiographic Findings:

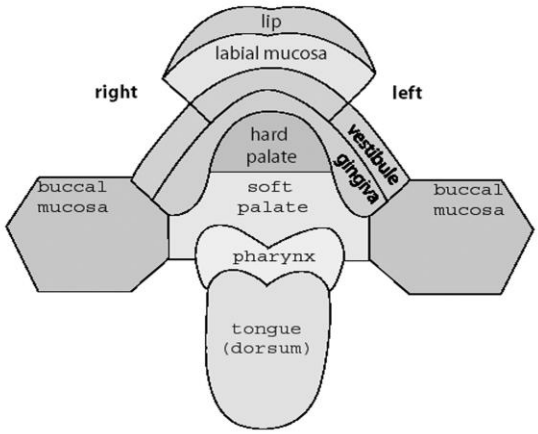
Clinical Impression:

Nature of Operation:

Clinical photographs taken? ☐ yes ☐ no Radiographs submitted? ☐ yes ☐ no Fixative: ☐ 10% formalin ☐ other _____

Indicate location of lesion on graphic:





Part D – Insurance Information -- Please send a copy of the patient's MEDICAL insurance cards (front and back).

Notice to patient regarding billing:
In addition to fees charged by your practitioner for the evaluation and biopsy of your oral lesion, a fee will be charged by the institution performing the tissue preparation, microscopic evaluation, and diagnosis; the University of Iowa College of Dentistry Department of Oral Pathology. The bill will be submitted to your medical insurance, if provided, and the portion of the fees not covered by your insurance will be billed to you by the business office of the University of Iowa College of Dentistry.

I acknowledge my responsibility for fees charged by the University of Iowa College of Dentistry Department of Oral Pathology.

_____ _____
Signed name Date

To submit to patient's insurance:
Please enclose a copy of the front and back of the patient's MEDICAL insurance card, or a printout of patient information. Please provide the following information:

Name of Subscriber:_____
Subscriber's DOB:_____
Relationship to Patient:_____
☐ Copy of insurance enclosed ☐ No insurance

We CANNOT process insurance without the subscriber's name & date of birth