TEXAS A&M UNIVERSITY
School of Dentistry

ORAL PATHOLOGY SERVICES
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DATE	☐ EMAIL RESULTS ☐ FAX RESULTS	PATH NUMBER
PATIENT'S NAME (LAST, FIRST)		BILL TO *(Please check one.)*
ADDRESS		☐ Doctor ☐ Patient ☐ Medical Insurance ☐ Dental Insurance ☐ Medicare/Medicaid ☐ Monarch
CITY / STATE / ZIP		*If nothing is marked, the doctor's office will be billed.*
AGE / SEX / RACE / PATIENT'S DATE OF BIRTH		

PROVISIONAL DIAGNOSIS	**BILLING INFORMATION *(Please type or print clearly.)*** **PATIENT ADDRESS, DATE OF BIRTH, AND HOME TELEPHONE REQUIRED**	
CASE HISTORY AND DESCRIPTION	INSURED'S NAME	PATIENT'S HOME TELEPHONE
	PATIENT'S SS #	INSURED'S DATE OF BIRTH
	INSURANCE COMPANY	INSURED'S SS #
	INSURANCE ADDRESS	INSURANCE TELEPHONE
	INSURANCE GROUP #	INSURANCE POLICY #
BIOPSY LOCATION: _____ ☐ INCISIONAL ☐ EXCISIONAL	MEDICARE #	MEDICAID #
RADIOGRAPHS: ☐ YES ☐ NO ☐ ENCLOSED		

DOCTOR'S NAME	LAB USE ONLY *(Do not write in this space.)*			
ADDRESS	☐ 88161	☐ 88305	☐ 88311	☐ 88342
CITY / STATE / ZIP	☐ 88302	☐ 88305 LT	☐ 88312	☐ 88341
PHONE / FAX	☐ 88304	☐ 88307	☐ 88313	☐ 88_____
EMAIL	☐ 88304 LT	☐ 88309	☐ 88321	☐ 88_____
	ICD10 Dx Code: _____			