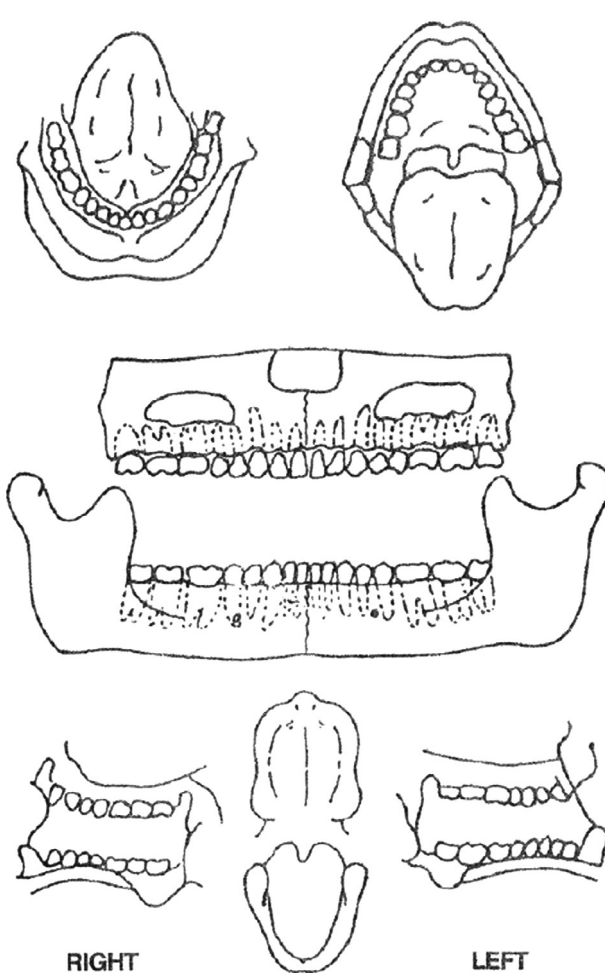


<p><b>PATIENT INFORMATION</b> (PLEASE PRINT IN BLACK INK)</p> <hr/> <p>Last Name _____ First _____ MI _____</p> <hr/> <p>Address _____ Birth Date _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <hr/> <p>City _____ SS # _____</p> <hr/> <p>State _____ Zip _____ Home Phone _____</p> <hr/> <p><b>INSURANCE BILLING INFORMATION</b> (PLEASE ATTACH CARD OR PRINT IN BLACK INK)</p> <p><b>BILL TO:</b> <input type="checkbox"/> Office/Clinician <input type="checkbox"/> Patient <input type="checkbox"/> Demographic Sheet Attached <input type="checkbox"/> Copy of Medical Insurance(s) Attached</p> <p><b>INSURANCE NAME:</b> _____</p> <hr/> <p>Subscriber Last Name _____ First _____ MI _____</p> <hr/> <p>Beneficiary / Member # _____ Group # _____</p> <hr/> <p>Claims Address _____ City _____ State _____ Zip _____</p> <p><b>RESPONSIBLE PARTY:</b> <input type="checkbox"/> Patient <input type="checkbox"/> Other (complete below)</p> <hr/> <p>Name _____</p> <hr/> <p>Address _____ City _____ State _____ Zip _____</p>	<p style="text-align: center;"><b>CLIENT INFORMATION</b></p> <hr/> <p><b>ORDERING CLINICIAN</b></p> <p>Clinician Name _____</p> <hr/> <p>Clinician Phone _____</p> <hr/> <p>Clinician Email _____</p> <p><input type="checkbox"/> Call results to phone number: ( _____ ) _____</p> <p><input type="checkbox"/> Fax report to: ( _____ ) _____</p> <hr/> <p><b>DIAGNOSIS CODE</b></p> <p>ICD-10 Codes</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>
<p><input type="checkbox"/> Check if clinical/radiographic images sent to <a href="mailto:stojani@ccf.org">stojani@ccf.org</a></p> <hr/> <p><input type="checkbox"/> Excision</p> <p><input type="checkbox"/> Biopsy</p> <p><input type="checkbox"/> Curettage</p> <p><input type="checkbox"/> Apicoectomy</p> <p><input type="checkbox"/> Specimen for Direct Immunofluorescence</p> <p><b>Biopsy Site(s):</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Clinical Findings and History:</b></p> <p>Size: _____</p> <p>Color: _____</p> <p>Radiographic Appearance: _____</p> <p>Duration: _____</p> <p>History/Other: _____</p> <p>_____</p> <p>_____</p> <p><b>Clinical Impression:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Special Requests/Comments/Prior Pathology:</b></p> <p>_____</p> <p>_____</p> <p>_____</p>	 <p>The diagrams include: 1) A lateral view of the maxilla and upper teeth. 2) An anterior view of the maxilla and upper teeth. 3) A panoramic radiograph (X-ray) of the entire jaw. 4) A lateral view of the mandible and lower teeth. 5) An anterior view of the mandible and lower teeth. 6) A lateral view of the maxilla and upper teeth. 7) An anterior view of the maxilla and upper teeth. 8) A lateral view of the mandible and lower teeth. 9) An anterior view of the mandible and lower teeth. The labels 'RIGHT' and 'LEFT' are placed below the corresponding diagrams.</p>