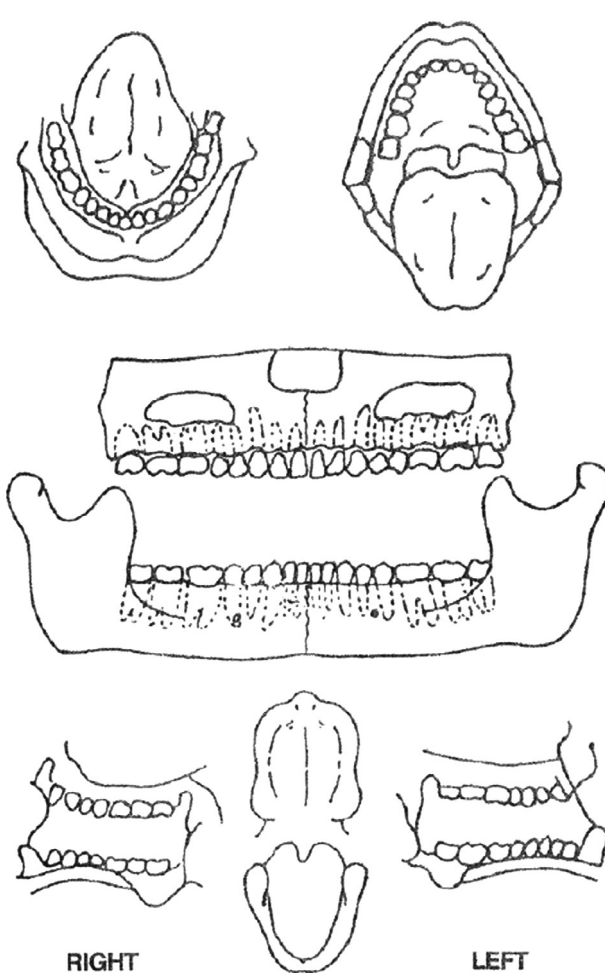


<p>PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)</p> <hr/> <p>Last Name _____ First _____ MI _____</p> <hr/> <p>Address _____ Birth Date _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <hr/> <p>City _____ SS # _____</p> <hr/> <p>State _____ Zip _____ Home Phone _____</p> <hr/> <p>INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)</p> <p>BILL TO: <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>INSURANCE NAME: _____</p> <hr/> <p>Subscriber Last Name _____ First _____ MI _____</p> <hr/> <p>Beneficiary / Member # _____ Group # _____</p> <hr/> <p>Claims Address _____ City _____ State _____ Zip _____</p> <p>RESPONSIBLE PARTY: <input type="checkbox"/> Patient <input type="checkbox"/> Other (complete below)</p> <hr/> <p>Name _____</p> <hr/> <p>Address _____ City _____ State _____ Zip _____</p>	<p>CLIENT INFORMATION</p> <hr/> <p>ORDERING CLINICIAN</p> <p>Clinician Name: _____</p> <p>Clinician Phone: _____</p> <p>Clinician Email: _____</p> <p>Date of Service: ____ / ____ / ____</p> <p>Collection Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.</p> <p><input type="checkbox"/> Call results to phone number: (____) _____</p> <p><input type="checkbox"/> Fax report to: (____) _____</p> <hr/> <p>DIAGNOSIS CODE</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 stojani@ccf.org</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>Biopsy Site(s):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Clinical Findings and History:</p> <p>Size: _____</p> <p>Color: _____</p> <p>Radiographic Appearance: _____</p> <p>Duration: _____</p> <p>History/Other: _____</p> <p>_____</p> <p>_____</p> <p>Clinical Impression:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Special Requests/Comments/Prior Pathology:</p> <p>_____</p> <p>_____</p> <p>_____</p>	 <p>The diagrams include:</p> <ul style="list-style-type: none"> Two views of the maxilla (upper jaw) and mandible (lower jaw) showing teeth and soft tissue outlines. A panoramic radiograph (X-ray) of the jaws. Three views of the maxilla and mandible: a right lateral view, a superior view, and a left lateral view.