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 **Steven D. Budnick, DDS**

 **Susan Muller, DMD**

ORAL and MAXILLOFACIAL PATHOLOGY

OTOLARYNGOLOGIC PATHOLOGY

TEST REQUEST FORM

**REQUIRED PATIENT INFORMATION REQUIRED DOCTOR INFORMATION**

**PATIENT NAME:** *(Please print.)* **SUBMITTING DOCTOR’S NAME:** *(Please print.)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

 Last First Middle

**DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AGE:** \_\_\_\_\_\_ **SEX:** **M** □ **F** □ **INSTITUTION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SS #: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **BLDG./SUITE:** \_\_\_\_\_\_\_\_\_\_ \_\_\_

**CITY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** **CITY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_

**PHONE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PHONE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient MEDICAL insurance information MUST be FAX:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**provided for ANY/ALL insurance to be filed. Please**

**attach a copy of front & back of insurance card.**  **NPI #** \_\_\_\_\_\_\_\_\_ \_\_\_\_

**MEDICARE# \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **GUARANTOR: \_** \_\_\_\_\_\_\_\_\_\_\_\_ **(Person legally responsible for** **bill - e.g. parent of**

**MEDICAID# \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **minor child.)**

**INSURANCE COMPANY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POLICY#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GROUP#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CITY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_

**ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **RELATIONSHIP: □SELF** □**SPOUSE** □ **DEPENDENT**

**CITY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_\_\_\_\_\_ **SUBSCRIBER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHONE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ATTENTION:** **All material submitted (slides, containers etc.) must be labeled with patient name and second identifier accompanied by requisition. When ordering tests in which Medicare reimbursement will be sought, physicians should ONLY order tests which are medically necessary for diagnosis or treatment.**

**To meet Federal Compliance Standards, ICD-10 code must be included. ICD-10 CODE: 1.** \_\_\_\_\_\_\_\_\_ **2.** \_\_\_\_\_\_\_\_\_

**DATE SPECIMEN TAKEN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPECIMEN TYPE: □ INCISIONAL BIOPSY**

**SIZE OF LESION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LOCATION OF BX:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLINICAL HISTORY: \_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2701 North Decatur Road, Decatur, GA 30033 ● P: (404) 501-7445 ● F: (404) 501-7460

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 **□ EXCISIONAL BIOPSY**

**CLINICAL DIAGNOSIS:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RADIOGRAPH SENT:** \_\_\_\_\_\_\_\_

**CLINICAL PHOTO SENT:** \_\_\_\_\_\_\_\_