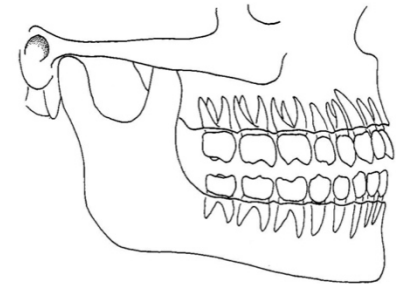
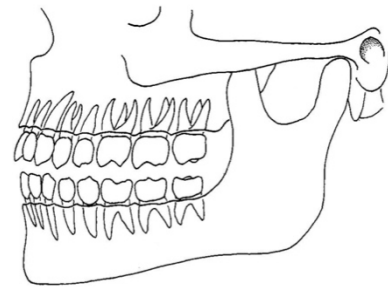
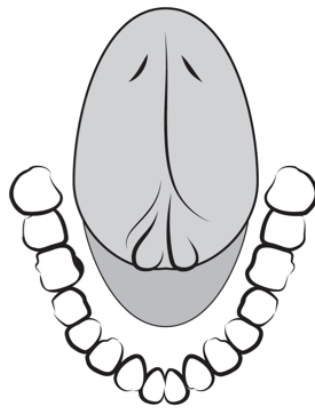
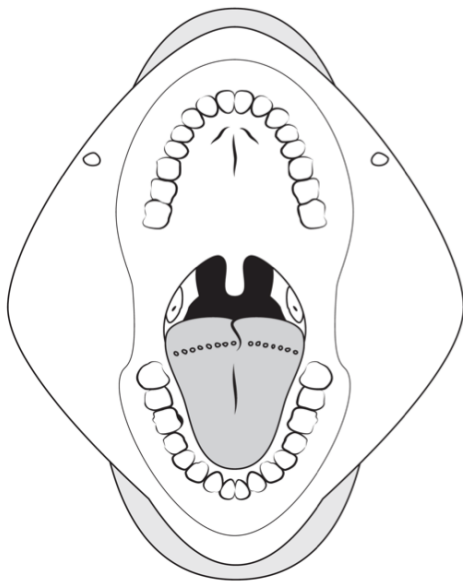


Patient Name (Last, First)	D.O.B.	Age	Sex
Patient Address	State	ZIP	
Social Security #	Tel.		
Submitting Doctor's name	Tel.	Fax	
Submitter's Office Address	State	ZIP	
	Email:		
Date of Biopsy	Specific Biopsy Site		
SOFT TISSUE SPECIMEN		INTRAOSSEOUS SPECIMEN	



HISTORY AND CLINICAL FINDINGS (Please email related photos & radiographs to poreda@uchc.edu)
(History, clinical data, lesion type, color, texture, radiographic features, Hx of previous biopsies)

Provider's Signature:

For UCONN OP Lab Use Only:
Pathologist's Dx, Micro, & Comments:

CLINICAL IMPRESSION/ DIFFERENTIAL DIAGNOSIS:

- 1.
- 2.
- 3.

MEDICAL INSURANCE INFORMATION (NOT DENTAL) (Please attach copies of patient medical insurance cards)

MEDICARE ID # Provider MUST be enrolled with PECOS	
MEDICAID OF CT ID #	
PRIMARY INSURANCE NAME:	Ins. ID #:
	D.O.B.
SECONDARY INSURANCE NAME:	Ins. ID #:
	D.O.B.



Easwar Natarajan BDS, DMSc
Professor and Chair, Oral Pathology
Director, UConn Oral Pathology Biopsy Service
Diplomate, American Board of Oral & Maxillofacial Pathology
Email: natarajan@uchc.edu

Jenna Ward, DMD
Assistant Professor, Oral Pathology
Diplomate, American Board of Oral & Maxillofacial Pathology
Email: jeward@uchc.edu

Ellen Eisenberg, DMD
Professor Emerita, Oral Pathology
Consulting Advisor
Diplomate, American Board of Oral & Maxillofacial Pathology
Email: eeisenberg@uchc.edu

School of Dental Medicine
Oral Pathology Biopsy Service
CLIA ID# 07D0945946

263 Farmington Ave, MC-3913
Farmington, CT 06030
Telephone: 860 679 3333
Fax: 860 679 3765
Clinical consultations: 860 679 3170

PATIENT PLEASE NOTE

The tissue obtained today will be sent to the University of Connecticut Oral Pathology Biopsy Service for processing and microscopic examination by a Board-Certified Oral Pathologist. A separate fee is charged for this service in addition to fees charged by your doctor for the surgical procedure.

-- RELEASE OF INFORMATION --

I hereby authorize and direct my healthcare plan to pay University Physicians at UConn Health for analysis of my tissue. I authorize the release of any medical information pertaining to the examination of the specimen(s) that is necessary to process the insurance claim for this service. In the event that my insurance does not cover this fee, or if my insurance covers only a portion of the fee, I agree to accept full financial responsibility for payment of charges (or balance of charges) rendered to me.

Signature of Patient or Legal Representative

Date

Redisclosure of this information is prohibited except with the specific written consent of the person to whom it pertains.