OP # _____

ORAL PATHOLOGY LABORATORY-UMMC SCHOOL OF DENTISTRY
2500 N. STATE STREET, JACKSON, MS 39216-4505
601-984-6092 (p) 601-984-4949 (f) oralpath@umc.edu
Dr. Tina Woods, DMD &

Patient Information

Name:_____ Race:_____ Gender:_____

Date of Birth:_____ SSN:_____

Address: _____

Phone: _____

Billing Information

MRN:_____ _____ ENC:_____

☐ **Bill Medical Insurance** (attach copies of insurance cards & subscriber name, DOB & SSN if other than patient

_____

☐ **Bill Patient** (NO medical insurance, patient has been informed of separate pathology fee)

☐ **Bill to Physicians office or other facility** _____

_____

Dental Provider Information

Doctor Name:_____ NPI:_____

Address:_____

Phone: _____ Fax: _____

Signature:_____ # of Biopsy Kits Needed (Multiples of 2:)_____

Specimen Information

Please Remember to Label Specimen Jar

Treatment Date: _____ Biopsy Incisional or Excisional: _____

Location of Lesion: _____ Size: _____

Clinical History_____

Appearance/Consistency: _____

Radiographic Appearance: _____

Clinical Diagnosis: _____

Clinical photos, X-rays or additional information may be emailed to oralpath@umc.edu

For Laboratory Use Only

N DOB MRN DOS DR _____

Accession Number: _____ Date Grossed: _____

Gross Description: _____

Codes: _____