



OP # _____

ORAL PATHOLOGY LABORATORY-UMMC SCHOOL OF DENTISTRY
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Dr. Lindsay Montague, DMD & Dr. Tina Woods, DMD &
Dr. Sigurds Krølls, DDS, MS, MSED

Patient Information

Name: _____ Race: _____ Gender: _____
Date of Birth: _____ SSN: _____
Address: _____
Phone: _____

MRN: _____ **Billing Information** 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: _____