**BLUEGRASS**
**ORAL PATHOLOGY**
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BLUEGRASS
ORAL PATHOLOGY

**PATIENT INFORMATION (PLEASE PRINT)**

| | | | | |
|---|---|---|---|---|
| **PATIENT NAME: LAST** | **FIRST** | **MI** | CLIENT REF # | **SOCIAL SECURITY NO.** |
| **GENDER** □ **M** □ **F** | **DATE OF BIRTH** | **DATE COLLECTED** | **PATIENT RACE** | REQUESTING DDS/DMD/MD |
| ADDRESS REQUIRED FOR ALL PATIENTS | | | □ BC/BS □ BGFH □ HUMANA □ AETNA □ UHC KY □ UHC OTHER | |
| | | | POLICY ID # | |
| ADDRESS (INCLUDE APT #) | | | GROUP | INSURANCE NAME |
| CITY | STATE | ZIP CODE | INS. ADDRESS | |
| PHONE: | | | CITY/STATE ZIP | |
| **RESPONSIBLE PARTY/POLICYHOLDER (IF OTHER THAN PATIENT)** | | | □ MEDICARE ID# | |
| ADDRESS (INCLUDE APT #) | | | □ MEDICAID ID# | |
| CITY | STATE | ZIP CODE | | |

**BIOPSY LOCATION:** _____

SIZE OF LESION: _____

PERTINENT CLINICAL HISTORY:

_____

_____

_____

**Mandatory**
**Signature and Date ⇒**
**Non-compliance prevents processing of the specimen.**

☐ **Need biopsy bottles**
☐ **Need FedEx mailing labels**

**Send images (JPEG, PNG, HEIC) to**
**photos@bluegrassoralpathology.com**
We are not able to open discs or USB devices.

CLINICAL PHOTOS SENT? ☐ YES ☐ NO

RADIOGRAPH SENT: ☐ YES ☐ NO

SPECIMEN TYPE: ☐ INCISIONAL BIOPSY
☐ EXCISIONAL BIOPSY

**CLINICAL DIAGNOSIS:** _____

_____

**SIGNATURE** **DATE**

**Clinician's Order for Histopathologic Examination**

**SIGNED SURGICAL OP NOTE REQUIRED**