UTHSC MEMPHIS ORAL & MAXILLOFACIAL DIAGNOSTIC SERVICES

875 Union Avenue, Room C-309
Memphis, TN 38163
PHONE: (901) 448-2569 FAX: (901) 448-6835
Email: utomds@uthsc.edu Website: http://uthsc.edu/dentistry/omds

Today's Date:	Date of Biopsy (if different):

PATIENT AND BILLING INFORMATION

Patient's Last name:	**First:**	**Middle:**	Age:	Sex: ◯ M ◯ F

Address:	City:	State:	Zip Code:

Is individual listed above responsible for payment? ◯ Yes ◯ No	If no, name of Insurance Policy Holder - Responsible Person (if patient is minor)	Ins. Policy Holder or Responsible Person SSN: - -	Ins Policy Holder Date of Birth: / /	Patient's Date of Birth: / /	Patient's Race:

Patient's Social Security no.: - -	Patient's Home phone (include area code): ( )	Cell phone (include area code): ( )
UT College of Dentistry Patient: ◯ Yes ◯ No	If Yes, Axium chart number:	◯ Patient Billing ◯ Doctor Billing ◯ Medical Ins. Billing (Include legible copy FRONT & BACK of insurance card) ◯ **BC/BS BLUE CARE?**

DOCTOR INFORMATION

Submitting Doctor's Name: Office Phone: ( )	Address: Office Fax: ( )	Dr's NPI #:	City / State:	Zip:

CLINICAL INFORMATION AND RELATED HISTORY

CLINICAL APPEARANCE OF LESION

Size:	Color and Shape:	Location (please also indicate on diagram on reverse side):	Other:
Duration:	Pain Scale: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	Radiographic Appearance (please include x-rays and indicate if we need to return them) :	

HISTORY OF PRESENT COMPLAINT

Relevant Past & Present History:	Pertinent Medical History:	Prior Biopsy: ◯ Yes ◯ No If "YES", Biopsy number: DSM ___ - ________

CLINICAL IMPRESSION

Clinical Impression:	Procedure Requested: ◯ Incisional Biopsy ◯ Excisional Biopsy ◯ Cytology ◯ Microbiology ◯ Immunofluorescence

NEED BIOPSY KITS:

Routine: Number of kits:_____________________________________ Michel's solution for Immunofluorescence _____________________________________

• **K. Mark Anderson, DDS, MS, Director** • **Shokoufeh Shahrabi-Farahani, DDS, MS, DMSc** • **Sarah E. Aguirre, DDS, MS**

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