☑ **Please check if you need additional biopsy kits**

For lab use only: **PHS**____-_____
**MRN:**_____

**SURGICAL PATHOLOGY SUBMISSION FORM**

University Dental Health Services (UDHS), Oral and Maxillofacial Pathology Biopsy Service
G-141 Salk Hall, 3501 Terrace Street, Pittsburgh, PA 15261
Lab: 412-648-8629; FAX: 412-383-9142; Billing: 412-624-7800
pittsburghoralpathology@dental.pitt.edu;

DATE OF SURGERY: _____

PATIENT NAME: _____ SOCIAL SECURITY #: _____
First Middle Initial Last

PATIENT ADDRESS: _____ PATIENT PHONE: _____

CITY, STATE, ZIP _____

PATIENT BIRTHDATE: _____ SEX: _____ RACE: _____

CLINICIAN NAME: _____ DENTAL LICENSE #: _____
CLINICIAN ADDRESS: _____ PHONE: _____
_____ FAX: _____
NPI #: _____

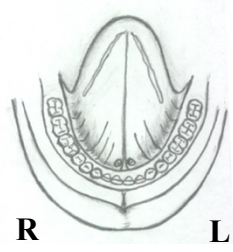
CLINICAL HISTORY AND DESCRIPTION OF THE LESION:
☐ Solitary ☐ Multiple lesions ☐ Ulcer(s) ☐ Nodule(s) ☐ Macule(s) ☐ Plaque(s) ☐ Intraosseous lesion
Duration: _____ Size: _____ Symptoms: _____
Consistency: _____ Color: _____ Shape: _____
Location(s) and/or tooth number(s): _____
Other findings: _____
If intraosseous: ☐ Pericoronal ☐ Periapical ☐ Interradicular ☐ Other: _____

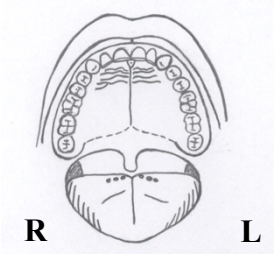
Relevant medical, dental, and/or social history: _____
_____

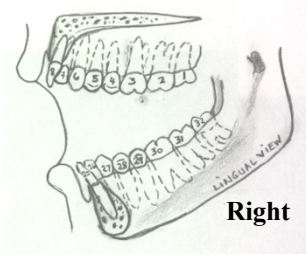
**CLINICAL IMPRESSION**: _____ **Previous Biopsy:** ☐ **No** ☐ **Yes**

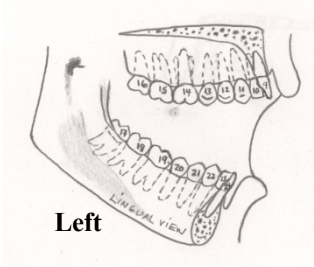
**PROCEDURE**: ☐ Excisional Biopsy ☐ Incisional Biopsy ☐ Other: _____

**Please indicate the location of the lesion**




**MEDICAL INSURANCE INFORMATION** (***Please fill out completely & sign waiver below***)

☐ No Insurance
Medical Insurance: ***ATTACH A LEGIBLE COPY OF THE FRONT AND BACK OF THE INSURANCE CARD***
☐ Patient ***IS*** the primary insurance subscriber ☐ Patient ***IS NOT*** the primary subscriber (If so, please complete the following):
Subscriber's Full Name: _____ Relationship to Patient: ☐ SPOUSE ☐ PARENT ☐ SELF
Subscriber's Date of Birth: _____

**WAIVER** (***Must be signed***)
**I understand that my biopsy will be sent to University Dental Health Services, Inc. (UDHS), an outside laboratory, for evaluation and diagnosis. I understand that I am financially responsible for all charges incurred by such service in the event that I do not have medical insurance, my insurance does not cover the service, or that I have not provided adequate information to UDHS. I further authorize the provider(s) to release the information necessary for payment of benefits.**

Patient Signature: _____ Date: _____
Parent/Guardian Signature (if minor): _____ Date: _____

Revised 2/22/22