CARL M. ALLEN, DDS, MSD
ASHLEIGH N. BRIODY, DDS, MS
CENTRAL OHIO ORAL AND MAXILLOFACIAL PATHOLOGY

PATHOLOGY REGISTRATION FORM

Central Ohio Skin & Cancer, Inc. 430 Altair Parkway, Suite 210, Westerville, Ohio 43082
Phone (614) 898-7546 ext. 734 (path lab); (614) 823-5597 (Dr. Allen); Fax (614)823-5468

ENTIRE FORM MUST BE FILLED OUT
COPY FRONT AND BACK OF MEDICAL INSURANCE CARD AND ATTACH

Required Patient Information: (PLEASE PRINT)

Patient Name _____ Date of Birth _____
Address _____ City, State, Zip _____
Male _____ Female _____ Phone Number _____

Primary Medical Insurance Information:

Insurance Company _____
Policy Holder _____
Relationship _____
SSN _____ DOB _____
Policy #_____ Group # _____

Secondary Medical Insurance Information:

Insurance Company _____
Policy Holder _____
Relationship _____
SSN _____ DOB _____
Policy #_____ Group # _____

Guarantor Information: (Financially Responsible Party, if different from above.)

Name & Relationship _____
Address _____
City, State, Zip _____ Phone Number _____

Required Doctor Information:

Submitting Doctor Name _____ Phone #_____
Address _____ City, State, Zip _____

ATTENTION: All materials submitted (slides, containers, etc.) must be labeled with patient's name and second identifier accompanied by a requistion. When ordering tests in which Medicare reimbursement will be sought, physicians should ONLY order tests which are medically necessary for diagnosis or treatment.

For Lab Use Only:

Date Received _____ Accession Number _____ MRN _____

CENTRAL OHIO ORAL AND MAXILLOFACIAL PATHOLOGY

CARL M. ALLEN, DDS, MSD
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CONSENT FORM

CENTRAL OHIO SKIN & CANCER, INC., 430 ALTAIR PARKWAY, SUITE 210, WESTERVILLE, OH 43082
614-898-7546, EXT. 737 (OFFICE)

Your doctor has determined that you need to have a biopsy procedure performed. The tissue removed during today's surgery will be sent to Dr. Carl Allen or Dr. Ashleigh Briody at Central Ohio Oral and Maxillofacial Pathology, a division of Central Ohio Skin & Cancer, Inc., for microscopic examination and diagnosis. Our board-certified Oral and Maxillofacial Pathologists will send a written report of the test results to your doctor. Your doctor will discuss the test results with you.

You will receive a bill directly from Central Ohio Skin and Cancer, Inc. for this service, which is separate from the fee charged by your surgeon. Based upon the different complexities of each tissue sample we receive, our fees may vary. In case of multiple tissue sites, each site will have a seperate fee. Decalcification of hard tissue and special studies take additional time and entail additional charges.

As a courtesy to you, we can bill your medical insurance company for reimbursement for our services. We need the following information to help process your medical insurance claim:

1. **A legible copy of the front and back of your medical insurance card.**
2. **Full name of the patient, date of birth, phone number, and address.**
3. **If the patient is a child or dependent, we need the guardian's full name, date of birth, and address.**

By forwarding the correct, complete insurance information, we can minimize delays in insurance billing. Please note that it is the responsibility of the patient or legal guardian to provide our office with complete and accurate insurance information. Claims will only be submitted when complete and accurate insurance information is received. You are responsible for this account, regardless of insurance. Bills should be paid promptly.

If your medical insurance is not listed on our list of participating insurance companies or if you are not insured, prepayment is **required**. Our basic pathology fee is $125. If decalcification or special studies are needed, those will be billed to you seperately. Please complete the credit card information below or enclose a check payable to Central Ohio Skin and Cancer, Inc.

☐ Mastercard ☐ Visa ☐ Discover

Credit Card Number: _____

Expiration Date: _____ CCV: _____

Name on card: _____ Signature: _____

I authorize release of information pertaining to the claim filed with my insurance company for the services provided by Central Ohio Oral & Maxillofacial Pathology, a division of Central Ohio Skin & Cancer, Inc. I understand that I am responsible for the prompt payment for these services.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Printed Name of Patient or Legal Guardian

CARL M. ALLEN, DDS, MSD
ASHLEIGH N. BRIODY, DDS, MS
CENTRAL OHIO ORAL AND MAXILLOFACIAL PATHOLOGY

BIOPSY SUBMISSION FORM

Central Ohio Skin & Cancer, Inc. 430 Altair Parkway, Suite 210, Westerville, Ohio 43082
Phone (614) 898-7546 ext. 734 (path lab); (614) 823-5597 (Dr. Allen); Fax (614)823-5468

PATIENT NAME: _____ DOB: _____

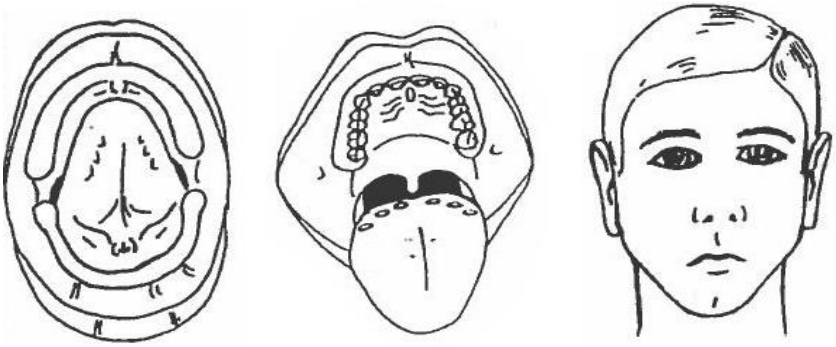
COLOR
___NORMAL
___ WHITE
___ RED
___ BLUE
___ BROWN

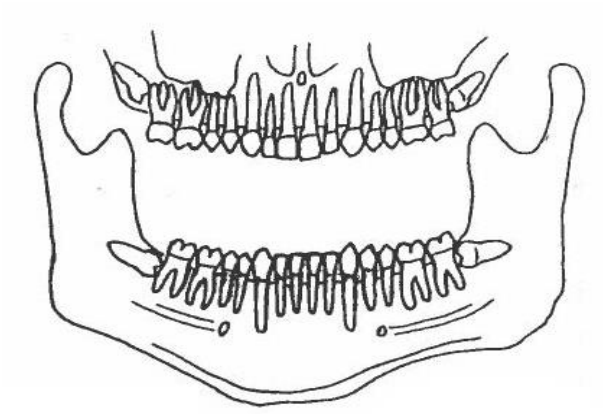
SHAPE
___PEDUNCULATED
___ SESSILE
___ FLAT
___ ULCERATED

CONSISTENCY
___ FIRM
___ SOFT
___ FLUCTUANT
___ PULSATILE

TEXTURE
___SMOOTH
___ GRANULAR/ROUGH
___ PAPILLARY

RADIOGRAPHIC FINDINGS
___ RADIOLUCENT
___ RADIOPAQUE
___ MIXED
___ UNILOCULAR
___ MULTILOCULAR
___ EXPANSILE
___ NON-EXPANSILE
___ WELL-DEFINED
___ POORLY DEFINED





ANATOMIC LOCATION:

SIZE:

PERTINENT MEDICAL HISTORY:

PROCEDURE:

□ EXCISIONAL BIOPSY
□ INCISIONAL BIOPSY
□ CYTOLOGY
□ EXCISIONAL BIOPSY, CURETTAGE

OPERATIVE FINDINGS:

WORKING DIAGNOSIS:

ADDITIONAL MATERIAL(S) (□ PLEASE CHECK IF RETURN OF MATERIALS IS REQUESTED.)
RADIOGRAPH(S) SENT ___ YES ___NO SLIDE(S)/PHOTOGRAPHS SENT ___YES ___NO

DOCTOR'S SIGNATURE: _____

BIOPSY DATE: _____

REVISED 10.01.19
For office use only: MRN _____