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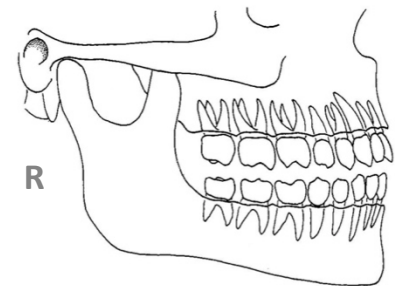
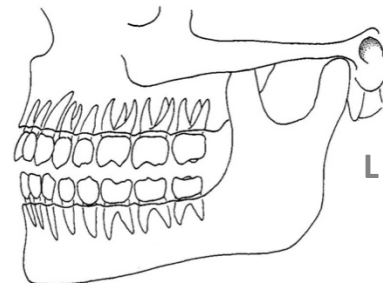
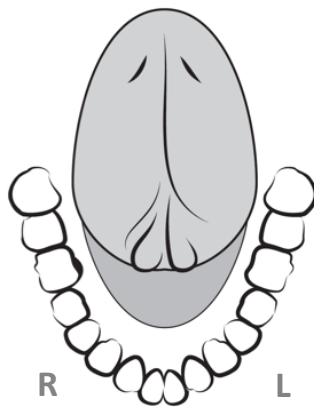
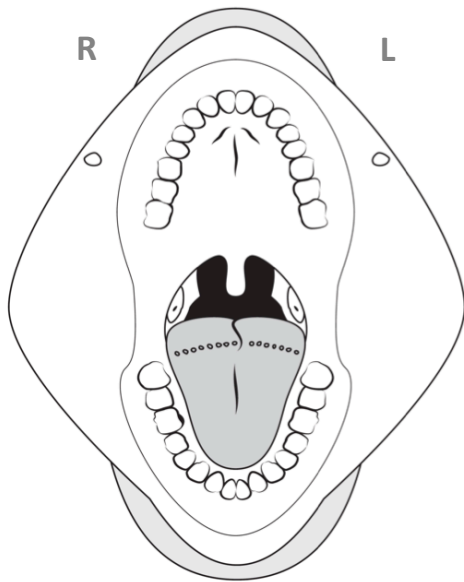
# UConn HEALTH

**Oral Pathology Biopsy Service**  
 Request for Histologic Evaluation of Surgical Specimen

<b>Patient Name</b> (Last, Middle, First)	<b>D.O.B.</b>	<b>Age</b>	<b>Sex</b>
<b>Patient Address</b>	<b>State</b>	<b>ZIP</b>	
<b>Social Security #</b>	<b>Tel.</b>		
<b>Doctor's name</b>	<b>Tel.</b>	<b>Fax</b>	
<b>Address</b>	<b>State</b>	<b>ZIP</b>	
<b>Date of Biopsy</b>	<b>Specific Biopsy Site</b>		

**SOFT TISSUE SPECIMEN**

**INTRAOSSEOUS SPECIMEN**



**HISTORY AND CLINICAL FINDINGS**

(Physical data, size, shape, color, texture, radiographic appearance, Hx of previous biopsies)

**For UConn OP Lab Use Only:**

Pathologist's Dx:

**CLINICAL IMPRESSION/ DIFFERENTIAL DIAGNOSIS:**

- 1.
- 2.
- 3.

Micro & Comments

**MEDICAL INSURANCE INFORMATION (NOT DENTAL) (Please attach copies of patient medical insurance cards)**

<b>MEDICARE ID #</b> Provider MUST be enrolled with PECOS	
<b>MEDICAID OF CT ID #</b> Non-CT Medicaid not accepted	
<b>PRIMARY INSURANCE NAME:</b>	<b>Ins. ID #:</b>
<b>Policy Holder's Name</b> (if other than Patient)	<b>D.O.B.</b>
<b>SECONDARY INSURANCE NAME:</b>	<b>Ins. ID #:</b>
<b>Policy Holder's Name</b> (if other than Patient)	<b>D.O.B.</b>

# UConn HEALTH

## School of Dental Medicine Oral Pathology Biopsy Service

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Clinical Consultations: 860-679-3170

## PATIENT PLEASE NOTE

The tissue obtained today will be sent to the University of Connecticut Oral Pathology Biopsy Service for processing and microscopic examination by a board-certified oral pathologist. A separate fee is charged for this service in addition to fees charged by your doctor for the surgical procedure.

### -- RELEASE OF INFORMATION --

I hereby authorize and direct my healthcare plan to pay University Physicians at UConn Health for analysis of my tissue. I authorize the release of any medical information pertaining to the examination of the specimen(s) that is necessary to process the insurance claim for this service. In the event that my insurance does not cover this fee, or if my insurance covers only a portion of the fee, I agree to accept full financial responsibility for payment of charges (or balance of charges) rendered to me.

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Signature of Patient or Legal Representative

Date

**Redisclosure of this information is prohibited except with  
the specific written consent of the person to whom it pertains.**