StrataDx
CENTER FOR ORAL PATHOLOGY
ONE CRANBERRY HILL, SUITE 303
LEXINGTON, MA 02421
Telephone: 800-325-7284 Fax: 617-252-6563

PATIENT INFORMATION

_____
Date of Birth

Sex: ☐ Female ☐ Male

_____
Name (Last, First, Middle Initial)

_____
Address

_____
City State ZIP Code

_____
Telephone Number

_____
Medical Record Number (Optional)

BILLING INFORMATION

Primary Medical Insurance	Secondary Medical Insurance
Insurance Company	Insurance Company
Member ID	Member ID
Group Number	Group Number
Insured Name	Insured Name
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent	Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

SEND ADDITIONAL COPY OF REPORT TO

_____
*Doctor's Name

_____
*Fax

**Required information to forward reports*

CLINICAL INFORMATION

DATE OF PROCEDURE: _____

BIOPSY SITE: _____

Please use diagram on reverse side to indicate specific location

TYPE OF SPECIMEN:

☐ EXCISION ☐ INC BX ☐ CUR ☐ APICO

☐ Specimen for Immunofluorescence

PHYSICIAN SIGNATURE: _____

I certify that I have obtained the required authorization and assignment of benefits for the laboratory to bill when insurance billing has been requested above. Physician authorizes Strata Pathology Services to perform all appropriate laboratory services related to this specimen(s) and to bill payor/patient accordingly.

CLINICAL AND RADIOGRAPHIC FINDINGS:

☐ Clinical Photos/Radiographs Included

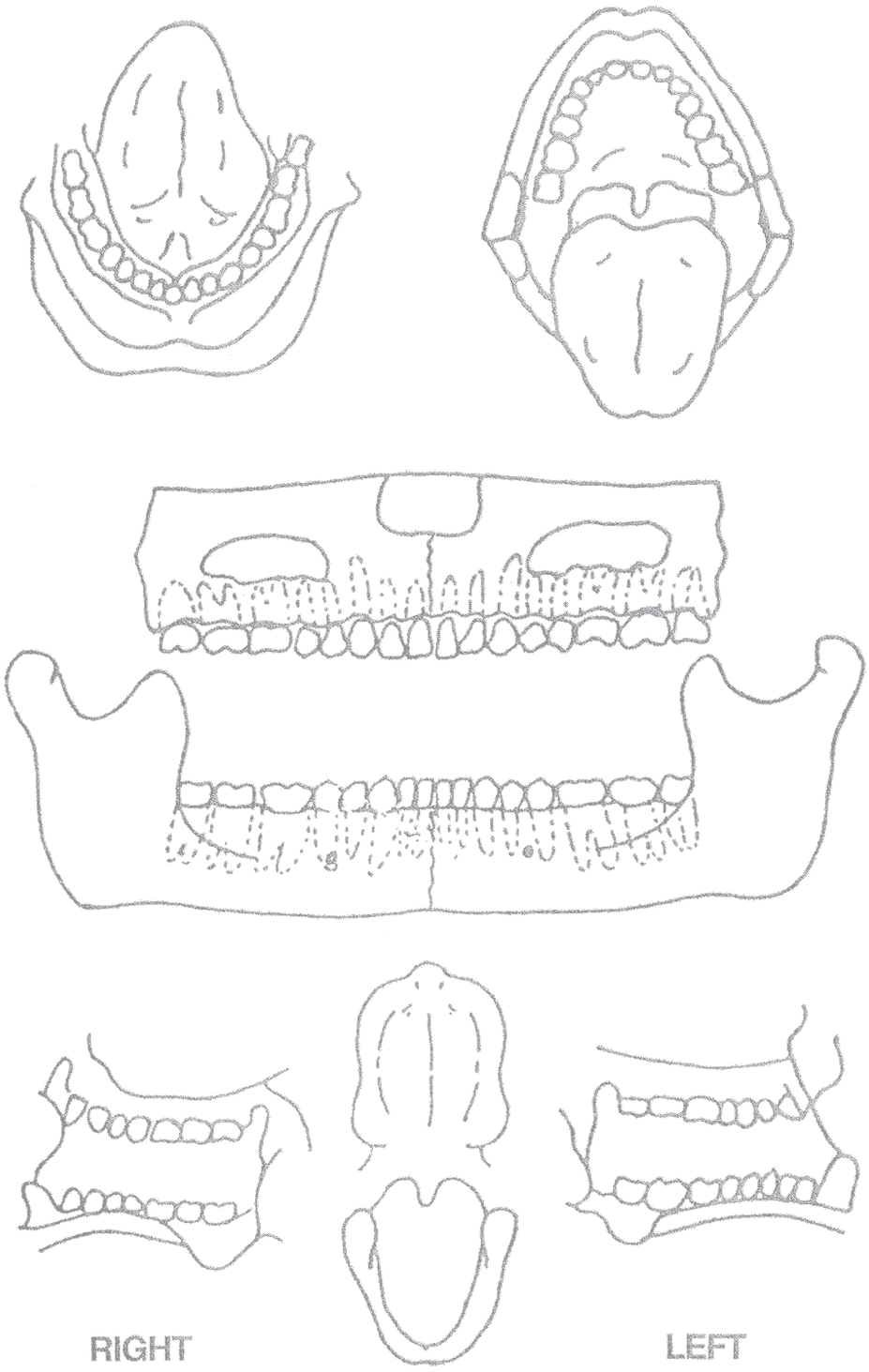
CLINICAL IMPRESSION:

To ensure processing, affix completed label to specimen container.

Patient Name/Initials:_____

Specimen Labels – 3100350

3100350 A	3100350 B
Patient Name/Initials: _____	**Patient Name/Initials:** _____
DOB: _____	**DOB:** _____
Site: _____	**Site:** _____


RIGHT
LEFT

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