RUTGERS
School of Dental Medicine

Rutgers University Diagnostic Services
Shruti Kashikar, DDS

Rutgers, School of Dental Medicine, Room D-860
P.O. Box 1709, 110 Bergen Street, Newark, NJ 07103
Billing Inquiries: (973) 972-4603 ♦ FAX (973) 972-2441
All Other Inquiries: (973) 972-1646 ♦ FAX (973) 972-3164

For Laboratory Use Only		
Lab Accession #		
Date:	Time:	
Previous Biopsy #		
Additional Stains		
Recuts	Deeper	Levels
Other		
Verbal Report		
Slide Sent		
Conference Case		
X-ray Received		

BIOPSY EXAMINATION REQUEST

THE ATTACHED PATIENT CONSENT FOR ORAL PATHOLOGY SERVICES MUST BE SIGNED BY THE PATIENT OR LEGALLY RESPONSIBLE PERSON AND MUST BE ENCLOSED WITH THE SPECIMEN TO AVOID A PROCESSING DELAY

PATIENT INFORMATION: (Please fill out completely and print clearly): NOTE: All information is required.

Name (Last)	(First)		Gender (M/F)
Address	City	State	Zip Code
SS#	Date of Birth		
Home Phone: ( )	Work Phone: ( )		
Medicare # (Please attach xerox copy of Medicare card.)	Medicaid # (Please attach xerox copy of Medicaid card.)		

SEND BILL TO:

☐ Patient

☐ Financially Responsible Party: ☐ Spouse ☐ Parent ☐ Other _____

(If different than above)

Name (Last)	(First)		Gender (M/F)
Address	City	State	Zip Code
SS#	Employer:		
Home Phone: ( )	Work Phone: ( )		

REQUESTING DOCTOR INFORMATION

NAME:	SIGNATURE	
ADDRESS:	CITY STATE ZIP CODE	
PHONE: FAX: ( ) ( )	NPI #	Date of Biopsy (Required)
Email Address:		

SUPPLIES REQUESTED: ☐ Biopsy Kits (Qty. _____) **NJDS CHART #, IF APPLICABLE** _____

REQUESTING DOCTOR - PLEASE FILL OUT THE REVERSE SIDE OF THIS FORM

THIS SECTION TO BE COMPLETED BY THE REQUESTING DOCTOR (Please fill out completely):

History, Clinical Description and Impression: _____

_____

_____

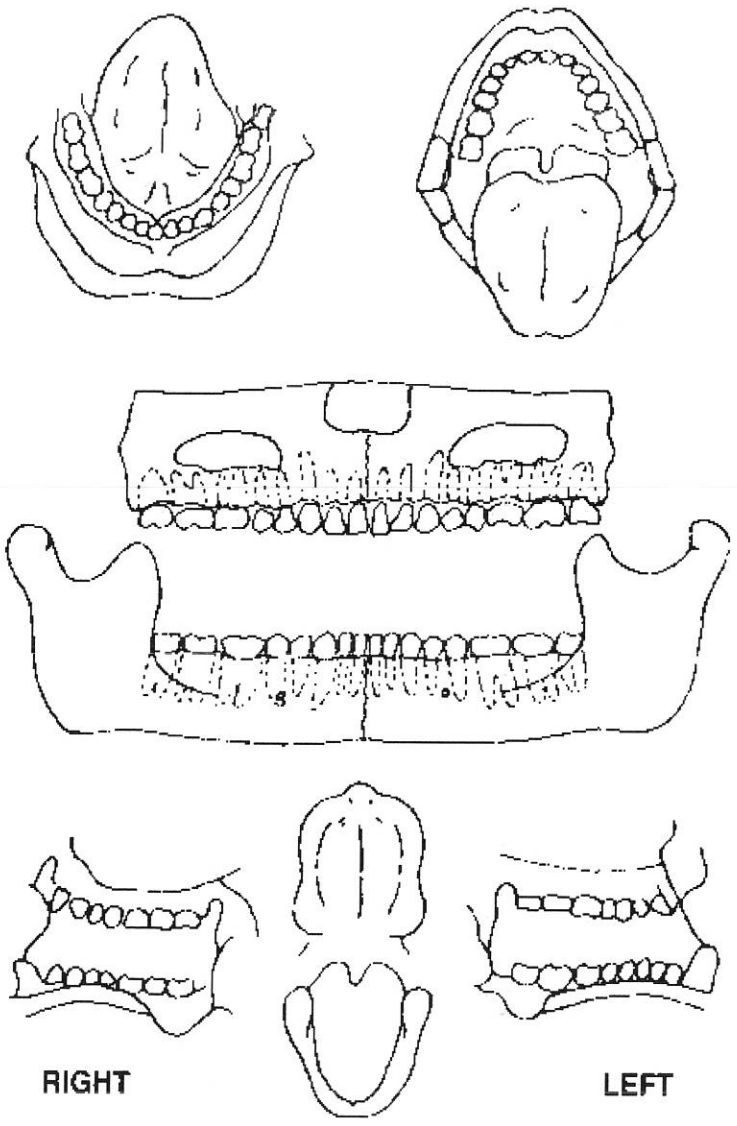
_____

Location of Biopsy (please see diagrams): _____

Associated tooth number _____ Tooth Vitality: ☐ Vital ☐ Nonvital Radiographs sent: ☐ Yes ☐ No

Previous Biopsy (diagnosis and/or NJDS Accession #, if applicable): _____

Mucosal Color:	☐ White	Surface Features:	☐ Flat	X-ray Findings:	☐ Radiolucent	Procedure:	☐ Incisional Biopsy
	☐ Red		☐ Exophytic		☐ Radiopaque		☐ Excisional Biopsy
	☐ Pink		☐ Nodular		☐ Mixed		☐ Curettage
	☐ Yellow		☐ Papillary		☐ Pericoronal		☐ Marginal Resection
	☐ Pigmented (Blue, Black, Brown)		☐ Ulcerated		☐ Periapical		☐ Aspiration
			☐ Submucosal		☐ Interradicular		☐ Smear
					☐ No abnormality		☐ Extraction



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DOCTOR: Please have your patient read, sign and date this consent form prior to your biopsy. The completed form must be enclosed with the specimen. Please make a photocopy of this signed form for your patient.

PATIENT: Notice of our privacy practices may be found at http://sdm.rutgers.edu/patients/hipaa-en.htm.

CONSENT FOR MICROSCOPIC TISSUE EVALUATION

Your doctor has done a thorough examination of your mouth and has determined that you need to have a biopsy procedure performed. The tissue removed during today's surgery will be sent to the New Jersey Diagnostic Services for microscopic examination and diagnosis. Your doctor is ensuring your good health by making sure that any abnormal tissue removed is examined microscopically so that a definitive diagnosis can be made and the correct treatment rendered. Our board-certified Oral and Maxillofacial Pathologists will fax and/or mail 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 New Jersey Diagnostic Services for this service, which is separate from the fee charged by your surgeon. Based upon the differing complexities of each tissue sample we receive, our fees may vary. In case of multiple tissue sites, each site will have a separate fee. Decalcification of hard tissue such as bone and special stains entail additional charges.

We do not submit claims to private insurance companies on your behalf; however, we are a Medicare and Medicaid provider. Payment is due when the bill is received. For your convenience, we accept a number of different credit cards.

In order for New Jersey Diagnostic Services to process your biopsy specimen, you must sign and date the statement below.

I have read and understand the above, and consent to microscopic tissue evaluation of this biopsy specimen. I understand that I am responsible for payment for all services provided by New Jersey Diagnostic Services.

New Jersey Diagnostic Services has my permission to release medical or other information necessary to submit claims to my insurance company on my behalf. If a financially responsible party has been designated, I authorize New Jersey Diagnostic Services to communicate to them information necessary for billing and insurance purposes. This consent will be valid for one year from the date of signed.

Signature of Patient, Legal Guardian or Holder of Power of Attorney	Print Name	Date