



Lightmic Consulting, LLC
Oral Maxillofacial Pathology & Forensics

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LMC Accession # _____
Date Received _____

BIOPSY EXAMINATION (PATHOLOGY) REQUEST

Your doctor has determined that you need to have a pathology examination of your biopsy specimen. Lightmic Consulting, LLC will perform a gross & microscopic examination by a board certified Oral Maxillofacial Pathologist, a specialist in the oral maxillofacial complex. Electronic (fax & or .PDF) and written report will be sent to your doctor who will discuss the test results with you.

Forward white original to lab, practice retain yellow copy & pink copy to patient

PATIENT	Last Name	First name	MI	Home Phone	Work Phone	Cell #	
	Patients Address: (apt # if applicable)				City	State & Zip	
	Age	DOB	Gender: [M] - [F]	SSN	email		
	INSURANCE Attach copy of MEDICAL INSURANCE CARDS or fill in below						
	IF SELF PAY: Please provide credit card info						
	Insurance Plan Name or Credit Card Type			Subscriber Name & DOB or Card Holder		Relation to Patient: [] Self [] Spouse [] Child	
	Subscriber ID # or Credit Card #			Group or Policy # or CC Expiration Date		Insurance Plan Phone #	
	ALL PATIENTS - PLEASE READ, SIGN BELOW & PATIENT CONSENT (ATTACHED)						
	You will receive <u>one invoice (includes both diagnostic & technical)</u> upon completion of pathology services (for total or balance) at which time payment is due.						
	I, the undersigned, permit release to my insurance company or agent information concerning this diagnostic analysis. <u>I acknowledge that I am financially responsible for all fees and I am aware payments from medical insurance plans vary.</u> The information provided herein is accurate.						
Parent or guardian signature (if child is under 18 years old) Date:							

REQUESTING DOCTOR - CLINICAL INFORMATION		
Anatomic Diagram on Reverse Side		
<u>Doctor's Name</u>	NPI number <u>if new</u> contributor	Biopsy date:
Street Address:		City
		State & Zip
Phone	Fax	Email address
1. Location of lesion:		
2. History & Clinical Information		
3. Clinical Impression:		

