oral pathology consultants
at The Ohio State University

2196 Postle Hall / 305 W. 12th Avenue
Columbus, Ohio 43210
Tel: 614-292-6577 / Fax: 614-292-9384

FINANCIAL RESPONSIBILITY AND INSURANCE INFORMATION

Please give your medical and dental insurance cards to your referring provider's office along with your driver's license so they may copy and enclose with your biopsy specimen.

For Lab Use Only

Date Received ____/____/_____

Pt. ID #_____

Accession # _____

Patient Name: _____

RESPONSIBLE PARTY INFORMATION:

Name: _____ Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Date of Birth:_____ Social Security # _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

Street City State Zip

Employer: _____ Phone: _____

☐ No medical or dental insurance coverage – SELF-PAY PATIENT *(You will receive a statement for all charges incurred)*

Primary Medical Insurance ****IMPORTANT**** Please only list MEDICAL insurance, as our services are not covered by dental insurances.

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber Birthdate	
Identification #		Subscriber S.S. #	
Group #		Employer Name	

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Subscriber Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Is subscriber address same as patient address? ☐ Yes ☐ No

If No, Address: _____

Secondary or Supplemental Medical Insurance OR Primary Dental Insurance (if applicable)

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber Birthdate	
Identification #		Subscriber S.S. #	
Group #		Employer Name	

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Subscriber Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Is subscriber address same as patient address? ☐ Yes ☐ No

If No, Address: _____

FOR PATIENTS WHO RESIDE IN A SKILLED NURSING FACILITY Please complete the following:

Facility Name: _____ Phone Number: _____

Contact Name: _____