Oral & Maxillofacial Pathology
1430 John Wesley Gilbert Drive
Augusta, GA 30912
(706) 721-2721 ext. 8486 (Phone)
(706) 721-4937 (Fax)

AUGUSTA UNIVERSITY

Biopsy Submission Consent and Payment Authorization Form

Patient Name: _____

I understand that the biopsy specimen taken today will be sent to the Oral and Maxillofacial Pathology Laboratory at the Dental College of Georgia at Augusta University, for testing. In some cases, additional non-routine testing may be necessary, which will generate additional charges.

- Please contact our office (see above) with any questions you may have concerning charges.

I understand that this is a medical procedure and I should present my medical insurance information at this time for claim filing by the Dental College of Georgia.

I understand that I will be responsible for testing fees or balances that are not covered by my medical insurance.

Patient's Signature:_____ Date:_____

GUARANTOR / PRIMARY INSURANCE HOLDER'S INFORMATION (OTHER THAN PATIENT): If the patient is a minor (under the age of 18), the following information is REQUIRED from the patient's parent or legal guardian. The primary insurance holder's information is REQUIRED only if the primary insurance holder is NOT the patient. If none of these apply, leave this section blank.

Guarantor's / **Primary Insurance Holder's Name**: _____

Address: _____

Date of Birth: _____ SS#:_____

Phone Number:_____ **Relationship to Patient**: _____

Guarantor's / **Primary Insurance Holder's Signature**: _____ Date: _____

Please include copies of the patient's, guarantor's or primary insurance holder's **MEDICAL INSURANCE CARD(S)** (FRONT AND BACK) indicating primary and secondary insurance as it applies.
Thank you!

Updated: 03/02/2018