PATHOLOGY ASSOCIATIES
OF GREENVILLE, P.A.
8 MEMORIAL MEDICAL COURT, SUITE 1, GREENVILLE, SC 29605
864-295-3492, 864-295-4817 (fax)

LABORATORY USE ONLY

CHART #

PHYSICIAN

ACCT. # | PHONE #

CASE # ______

PATIENT INFORMATION

PATIENT NAME (LAST) (FIRST) | SEX M F | BIRTHDATE

PATIENT ADDRESS | SOC. SEC. #

CITY | STATE | ZIP CODE | PATIENT PHONE #

REQUESTING PHYSICIAN | PHYSICIAN SIGNATURE

CYTOLOGY REQUEST

COMPLETE THE FOLLOWING FOR PATIENT OR INSURANCE BILLING

BILL TO:

☐ DR./CLIENT (OFC) ☐ MEDICARE (INS) ☐ MEDICAID (INS) ☐ PATIENT (INS) ☐ OTHER INSURANCE (INS)

GUARANTOR NAME (IF OTHER THAN PATIENT)

ADDRESS

CITY | STATE | ZIP CODE

MEDICARE NUMBER | (SUFFIX)

MEDICAID NUMBER | (STATE)

OTHER INSURANCE (GROUP NAME) | (GROUP NO.) | (CONTRACT NO.)

CHECK IF YES

☐ BCP	☐ HYSTERECTOMY
☐ HORMONES	☐ POST MENOPAUSAL
☐ PREGNANT	☐ RADIATION
☐ POSTPARTUM	☐ PREV. ABNRML. CYTOLOGY
☐ BLEEDING	INDICATE #:
☐ DISCHARGE	☐ CHEMOTHERAPY

PATIENT HISTORY

AGE | LMP:

DATE OF LAST PAP SMEAR:

DIAGNOSTIC INFORMATION (ICD9 CODE)

PAP SMEAR (ICD9 CODE) ______

OTHER SPECIMEN (ICD9 CODE) ______

ADDITIONAL HISTORY:

INFORMATION

A12028 (10/19)