



Advance Pathology Services, P.C.

8865 Professional Drive, Suite 3
Cadillac, MI 49601
231-468-2346

Last Name _____ First Name _____ MI _____
 Birth Date ____/____/____ Sex ____ Patient's SSN ____/____/____
 Address _____ City _____ State _____
 ZIP Code _____ Telephone ____/____/____ (Or Attach Patient Demographics Sheet)

Policy Holder Name _____ Policy Holder DOB ____/____/____
 Policy Holder SSN ____/____/____
 Medicare _____ Medicaid _____ Medicare/Medicaid ID# _____
 Insurance Company _____
 Insurance ID# _____ Group # _____
 Patient is: Subscriber ____ Spouse ____ Dependent ____
 Medicare Coverage is: Primary ____ Secondary ____

Guarantee of Payment
 I understand I am responsible for my health deductibles, co-pays, non-covered and collection charges of the entire laboratory bill. I guarantee payment for whatever balance is not paid by my insurance company or self pay, if I have no insurance.
 Signature _____
 Date _____

Physician _____
 Address _____

 Copy to _____

Surgical/Nongynecologic Cytology Specimen
 Clinical Notes:
 Source:
 Operative Diagnosis:

Gynecological Cytology Specimen
 Diagnosis _____
 Source:
 Endocervix/Cervix/Vaginal
 Endocervix/Cervix
 Cervix/Vaginal
 Vaginal
 Other
 LMP: ____/____/____
 Menopause _____
 Pregnancy (weeks) _____
 Clinical History:
 Hysterectomy
 Post Partum
 Cervical Remnant
 High Risk
 Previous Positive HPV
 Hormones/Birth Control
 Radiation
 Previous Abnormal
 Gyn Cancer
 HGSIL
 LGSIL
 Atypia
 Other _____
 _____ Thin Prep Only
 _____ Thin Prep/HPV
 _____ Thin Prep/reflex HPV ___ASCUS only

DNA Probe
 _____ GC/Chlamydia Specimen: _____ ThinPrep
 _____ HPV _____ Urine
 _____ HSV _____ Swab/Source: _____
 _____ Trichomonas

Time Collected _____
 Date Collected _____
 I, the treating physician, order these tests for the diagnosis and treatment of this beneficiary or for screening purposes.
 Physician _____
 Specimen ID# _____