



**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:

HX of cancer: YES NO Type: \_\_\_\_\_  
 Site: \_\_\_\_\_

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  
 \_\_\_\_ Chlamydia/GC

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# \_\_\_\_\_