



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 _____

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# _____

Thin Prep PAP Only
 Thin Prep with HPV
 Thin Prep with reflex HPV
 Chlamydia/GC