TISSUE EXAMINATION FORM

TETON PATHOLOGY, P.C.

P.O. Box 4940
Jackson, Wyoming 83001 • (307) 733-6418 • (307) 734-0885 (Fax)

FOR LAB USE ONLY

Specimen Rec'd _____

Containers _____

Accession # _____

PATIENT DATA

LAST NAME	FIRST NAME		MI
ADDRESS		DOB	
CITY	STATE	ZIP CODE	SEX
PHONE #		SS #	

SPECIMEN DATA

DATE OF SPECIMEN(S)	FACILITY
SPECIMEN(S)	
PERTINENT Hx/COMMENTS	
SURGEON	
ATTENDING PHYSICIAN (IF OTHER THAN SURGEON)	

PATIENT INFORMATION (BELOW MUST BE COMPLETED)

SUBSCRIBER / GUARANTOR

ADDRESS

CITY / STATE / ZIP

RELATION TO PATIENT	PHONE #
D.O.B.	SS #
PRIMARY INSURANCE CO.	SECONDARY INSURANCE CO.
ADDRESS	ADDRESS
CITY / STATE / ZIP	CITY / STATE / ZIP
INSURED NAME	INSURED NAME
SS #	SS #

I authorize payment of medical benefits to TETON PATHOLOGY

SIGNED _____

IBF F TISS. EXAM 6/13

TISSUE SPECIMENS ARE REFERRED TO THE PATHOLOGIST BY YOUR PHYSICIAN FOR DIAGNOSIS AND TREATMENT INFORMATION.