Fleming Dermatopathology

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Please type or print CLEARLY Date _____

Referring physician _____

Patient's name _____ D.O.B. _____ ☐M ☐F
(Last) (First) (MI)

Date of surgery _____ MR # _____

DERMATOPATHOLOGY

Specimen #1: E-slip # _____ Site _____

☐ Processing Only Clinical _____

Procedure ☐Punch ☐Shave ☐Elliptical excision ☐Other _____

If slide (not tissue): Slide # _____ Prep'd by _____

Specimen #2: E-slip # _____ Site _____

☐ Processing Only Clinical _____

Procedure ☐Punch ☐Shave ☐Elliptical excision ☐Other _____

If slide (not tissue): Slide # _____ Prep'd by _____

Specimen #3: E-slip # _____ Site _____

☐ Processing Only Clinical _____

Procedure ☐Punch ☐Shave ☐Elliptical excision ☐Other _____

Specimen #4: E-slip # _____ Site _____

☐ Processing Only Clinical _____

Procedure ☐Punch ☐Shave ☐Elliptical excision ☐Other _____

Bill ☐Referring physician ☐Patient or third party

COMPLETE FOR PATIENT/INSURANCE BILLING

Patient address _____

City _____ ST _____ Zip _____ Patient SS # _____/_____/_____

Race _____ Marital status: ☐S ☐M ☐W ☐D

Patient phone _____ D.O.B. _____ EMPLR _____

Primary Ins. Co. name _____

Address _____ City _____ ST _____ Zip _____

Subscriber name _____ Relationship to patient _____

Policy # _____ Group # _____

Secondary Ins. Co. name _____

Address _____ City _____ ST _____ Zip _____

Subscriber name _____ Relationship to patient _____

Policy # _____ Group # _____