

Please type or print CLEARLY

Date _____

Referring physician _____

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

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 # _____