

100 Midland Ave • Port Chester, NY 10573

## (800) 388-3995 • Fax (914) 636-0932 PATIENT INFORMATION (PLEASE PRINT) Date Collected Date of Social Birth Sec. # Name: Last First Middle Initial Address: State: Zip: City: Work Home Phone Phone Sex: Chart #: M F Race: BILLING INFORMATION ATTACH A COPY OF INSURANCE CARD(S) - BOTH SIDES - OR COMPLETE BELOW PRIMARY INSURANCE: SECONDARY INSURANCE: ADDRESS: ADDRESS: CITY: STATE ZIP CODE: STATE NAME OF POLICYHOLDER: RELATIONSHIP TO INSURED: NAME OF POLICYHOLDER: RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT SELF SPOUSE DEPENDENT GROUP / CONTRACT #: ID# GROUP / CONTRACT #: Your patient's signature below authorizes this laboratory to provide the pathology services you requested, to bill his/her insurance company directly, and to release any medical information needed to determine the benefits payable. PATIENT'S SIGNATURE (REQUIRED) X DATE Physician's Signature Required for NY, NJ, MA and PA These offerings may require special stains as deemed appropriate for proper evaluation by the Dermpath Diagnostics Dermatopathologist. These additional tests will result in additional charges. CLINICAL INFORMATION (Please attach additional requisitions if necessary) LAB USE Clinical Description Clinical Diagnosis **Biopsy Site Biopsy Method** Punch Curette Shave Snip Excision Margins Punch Curette Margins Snip Punch Ourette Excision Snip Margins Curette Excision Punch Shave Snip Margins Previous Relevant Biopsy Number: PLEASE DO NOT WRITE BELOW THIS LINE. FOR LABORATORY USE ONLY. GROSS NOTES

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