

DATE COLLECTED: \_\_\_\_/\_\_\_\_/\_\_\_\_

IMMUNOFLUORESCENCE  RUSH  FROZEN SECTION  SLIDE PREP

PATIENT INFORMATION				
LAST NAME		FIRST NAME		M.I.
STREET ADDRESS				APT. #
CITY		STATE	ZIP CODE	
PATIENT PHONE NUMBER		PATIENT SOCIAL SECURITY NUMBER		
DATE OF BIRTH / /	AGE	SEX	PATIENT ID	

PHYSICIAN/CLIENT INFORMATION

BILLING / INSURANCE INFORMATION (attach a copy of insurance card - both sides)					
<b>BILL:</b>  <input type="checkbox"/> INSURANCE  <input type="checkbox"/> PATIENT  <input type="checkbox"/> MEDICARE  <input type="checkbox"/> MEDICAID  <input type="checkbox"/> PHYSICIAN	SUBSCRIBER PRIMARY INSURANCE		SUBSCRIBER SECONDARY INSURANCE		
	SUBSCRIBER NAME/ RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		SUBSCRIBER NAME/ RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
	COMPANY NAME		COMPANY NAME		
	ADDRESS		ADDRESS		
	CITY STATE ZIP CODE		CITY STATE ZIP CODE		
	EMPLOYER NAME		EMPLOYER NAME		
SUBSCRIBER DOB: / /	GROUP/CONTRACT#	MEMBER ID #			
SUBSCRIBER SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICARE #	MEDICAID ID #			

SEND DUPLICATE REPORT TO: \_\_\_\_\_ ADDRESS / FAX: \_\_\_\_\_

CLINICAL INFORMATION			
SITE	CHECK:	MARGINS?	CLINICAL DIAGNOSIS AND HISTORY
1	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION <input type="checkbox"/> OTHER	<input type="checkbox"/>	
2	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION <input type="checkbox"/> OTHER	<input type="checkbox"/>	
3	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION <input type="checkbox"/> OTHER	<input type="checkbox"/>	
4	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION <input type="checkbox"/> OTHER	<input type="checkbox"/>	
5	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION <input type="checkbox"/> OTHER	<input type="checkbox"/>	
6	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION <input type="checkbox"/> OTHER	<input type="checkbox"/>	

PHYSICIAN'S SIGNATURE X \_\_\_\_\_ DATE \_\_\_\_\_  
REQUIRED IN NY, NJ, MA, AND PA

DIFFICULT CASES SOMETIMES REQUIRE ADDITIONAL DIAGNOSTIC STAINS TO ASSIST THE DERMATOPATHOLOGIST IN MAKING A DEFINITIVE DIAGNOSIS. THE DIAGNOSTIC STAINS MAY RESULT IN ADDITIONAL CHARGES.

FOR LAB USE ONLY

ICD-9 Codes: