Dermpath Diagnostics®
New York

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PATIENT INFORMATION (PLEASE PRINT)

Date Collected ___ – ___ – ___

Date of Birth ___ / ___ / ___

Name: ___
Last First Middle Initial

Address: ___

City: ___ State: ___ Zip: ___

Home Phone ___ Work Phone ___

Sex: M F Race: ___ Chart #: ___

BILLING INFORMATION ATTACH A COPY OF INSURANCE CARD(S) - BOTH SIDES - OR COMPLETE BELOW

PRIMARY INSURANCE: COMPANY NAME:	SECONDARY INSURANCE: COMPANY NAME:
ADDRESS:	ADDRESS:
CITY: STATE ZIP CODE:	CITY: STATE ZIP CODE:
NAME OF POLICY HOLDER: RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT	NAME OF POLICY HOLDER: RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT
GROUP / CONTRACT #: ID #	GROUP / CONTRACT #: ID #
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.	SEND AN ADDITIONAL COPY OF THE REPORT TO:
PATIENT'S SIGNATURE (REQUIRED) X ___ DATE ___	NAME:
Physician's Signature ___ Date. ___	FAX:

Required for NY, NJ, MA, PA and WV

Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

CLINICAL INFORMATION (Please attach additional requisitions if necessary) LAB USE

Biopsy Site	Biopsy Method		Clinical Description	Clinical Diagnosis
	○ Punch ○ Shave ○ Snip	○ Curette ○ Excision ○ Margins		
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	○ Punch ○ Shave ○ Snip	○ Curette ○ Excision ○ Margins		

Previous Relevant Biopsy Number: ___

PLEASE DO NOT WRITE BELOW THIS LINE. FOR LABORATORY USE ONLY.

GROSS

NOTES