DERMPATH DIAGNOSTICS®
PATHOLOGY ASSOCIATES
100 Midland Ave • Port Chester, NY 10573
(800) 388-3995 • Fax (914) 636-0932

PATIENT INFORMATION (PLEASE PRINT)

Date Collected ____ - ____ - ____

Date of Birth ____ / ____ / ____ Social Sec. # ____ - ____ - ____

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 POLICYHOLDER: RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT	NAME OF POLICYHOLDER: 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.

PATIENT'S SIGNATURE (REQUIRED) X _____ DATE _____

Physician's Signature _____ Date: _____

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

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

Previous Relevant Biopsy Number: _____

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

GROSS	NOTES