

PATIENT INFORMATION						PHYSICIAN INFORMATION								
LAST NAME			FIRST NAME			M.I.								
STREET ADDRESS					APT. #									
CITY				STATE		ZIP CODE								
DATE OF BIRTH / /		AGE	SEX	PATIENT ID										
LAB USE ONLY			SITE 1			RX TYPE: ☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER			HISTORY/PREVIOUS BIOPSIES:			MARGINS? ☐		
			MEAS & CODE _____											
ATS ____ AGG ____ DYED ____ FR ____ FL ____ INT ____						CLINICAL IMPRESSIONS:								
LAB USE ONLY			SITE 2			RX TYPE: ☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER			HISTORY/PREVIOUS BIOPSIES:			MARGINS? ☐		
			MEAS & CODE _____											
ATS ____ AGG ____ DYED ____ FR ____ FL ____ INT ____						CLINICAL IMPRESSIONS:								
LAB USE ONLY			SITE 3			RX TYPE: ☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER			HISTORY/PREVIOUS BIOPSIES:			MARGINS? ☐		
			MEAS & CODE _____											
ATS ____ AGG ____ DYED ____ FR ____ FL ____ INT ____						CLINICAL IMPRESSIONS:								
LAB USE ONLY			SITE 4			RX TYPE: ☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER			HISTORY/PREVIOUS BIOPSIES:			MARGINS? ☐		
			MEAS & CODE _____											
ATS ____ AGG ____ DYED ____ FR ____ FL ____ INT ____						CLINICAL IMPRESSIONS:								
BILLING/INSURANCE INFORMATION (Attach a copy of insurance card – both sides)														
BILL		SUBSCRIBER PRIMARY INSURANCE						SUBSCRIBER SECONDARY INSURANCE						
☐ INSURANCE ☐ PATIENT ☐ MEDICARE ☐ MEDICAID ☐ PHYSICIAN		SUBSCRIBER NAME / RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Dependent						SUBSCRIBER NAME / RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Dependent						
		INSURANCE NAME						INSURANCE NAME						
		ADDRESS						ADDRESS						
		CITY			STATE		ZIP CODE	CITY			STATE		ZIP CODE	
		EMPLOYER NAME						EMPLOYER NAME						
		SUBSCRIBER DOB: / /		GROUP/CONTRACT #		MEMBER ID #		SUBSCRIBER DOB: / /		GROUP/CONTRACT #		MEMBER ID #		
		SUBSCRIBER SEX: ☐ Male ☐ Female		MEDICARE ID #		MEDICAID ID #		SUBSCRIBER SEX: ☐ Male ☐ Female		MEDICARE ID #		MEDICAID ID #		

PHYSICIAN's SIGNATURE (Required in NY, NJ, MA, and WV) X _____ DATE _____

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. In some cases, additional diagnostics stains may be required for proper evaluation as deemed appropriate by the DermPath Diagnostics Dermatopathologist. These additional tests will result in additional charges.