DERMATOPATHOLOGY REQUISITION

DERMPATH DIAGNOSTICS®
SOUTH FLORIDA

DATE COLLECTED: ____/____/____ TIME:_____ ☐RUSH

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	SEX	PATIENT ID
/ /		

PHYSICIAN INFORMATION

BILLING / INSURANCE

BILL:

☐ INSURANCE
☐ PATIENT
☐ MEDICARE
☐ MEDICAID
☐ PHYSICIAN

SUBSCRIBER PRIMARY INSURANCE (attach a copy of insurance card - both sides)

SUBSCRIBER NAME/ RELATIONSHIP TO SUBSCRIBER ☐SELF ☐SPOUSE ☐DEPENDENT

COMPANY NAME

ADDRESS

CITY	STATE	ZIP CODE

EMPLOYER NAME

SUBSCRIBER DOB: / /	GROUP/CONTRACT#	MEMBER ID #

SUBSCRIBER SEX: ☐Male ☐Female	MEDICARE #	MEDICAID ID #

PATIENT'S SIGNATURE X _____ **DATE** _____

CLINICAL INFORMATION

SITE	CHECK:	MARGINS?	CLINICAL DIAGNOSIS, HISTORY and ICD-9 Codes:
1	☐ EXCISION ☐ SHAVE ☐ PUNCH ☐ OTHER	☐	
2	☐ EXCISION ☐ SHAVE ☐ PUNCH ☐ OTHER	☐	
3	☐ EXCISION ☐ SHAVE ☐ PUNCH ☐ OTHER	☐	
4	☐ EXCISION ☐ SHAVE ☐ PUNCH ☐ OTHER	☐	
5	☐ EXCISION ☐ SHAVE ☐ PUNCH ☐ OTHER	☐	
6	☐ EXCISION ☐ SHAVE ☐ PUNCH ☐ OTHER	☐	
7	☐ EXCISION ☐ SHAVE ☐ PUNCH ☐ OTHER	☐	
8	☐ EXCISION ☐ SHAVE ☐ PUNCH ☐ OTHER	☐	

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

PHYSICIAN'S SIGNATURE (Required in NY, NJ, MA and PA) X _____ **DATE** _____

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