DERMPATH DIAGNOSTICS®
DERMPATH

100 Midland Ave • Port Chester, NY 10573
(800) 942-DERM • Fax (914) 934-9819

PATIENT INFORMATION (PLEASE PRINT)

Date Collected _____ - _____ - _____
(Required Information)

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

Name: _____
(Last) (First)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone _____ **Work Phone** _____

Sex: M F **Race:** _____ **Chart #:** _____

Send additional copy of report to: _____

Address: _____

Fax: (_____) _____ Mail copy? Y N

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.

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 ____/____/____

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

PRIMARY INSURANCE:
COMPANY NAME:

ADDRESS: CITY STATE ZIP

NAME OF POLICYHOLDER:

RELATIONSHIP TO INSURED:
☐ SELF ☐ DEPENDENT
☐ SPOUSE

GROUP#: ID #

SECONDARY INSURANCE:
COMPANY NAME:

ADDRESS: CITY STATE ZIP

NAME OF POLICYHOLDER:

RELATIONSHIP TO INSURED:
☐ SELF ☐ DEPENDENT
☐ SPOUSE

GROUP#: ID #

CLINICAL INFORMATION (Please attach additional requisitions if necessary)

Site	Bx Type	Clinical Description & Impression

☐ Check box if neoplasm/soft tissue mass is suspected. Margins/step sections will be performed.

Previous Relevant Case # (s):

LAB USE

LAB USE ONLY

For Lab Use Only

DPL-156-0010 (1/11)

DERMATOPATHOLOGY REQUISITION SLIP