

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			
<b>BILL:</b>  <input type="checkbox"/> INSURANCE  <input type="checkbox"/> PATIENT  <input type="checkbox"/> MEDICARE  <input type="checkbox"/> MEDICAID  <input type="checkbox"/> PHYSICIAN	<b>SUBSCRIBER PRIMARY INSURANCE</b> (attach a copy of insurance card - both sides)		
	SUBSCRIBER NAME/ RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		
	COMPANY NAME		
	ADDRESS		
	CITY	STATE ZIP CODE	
	EMPLOYER NAME		
	SUBSCRIBER DOB: / /	GROUP/CONTRACT#	MEMBER ID #
	SUBSCRIBER SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICARE #	MEDICAID ID #

PATIENT'S SIGNATURE   X   \_\_\_\_\_ DATE \_\_\_\_\_

CLINICAL INFORMATION		CHECK:	MARGINS?	CLINICAL DIAGNOSIS, HISTORY and ICD-9 Codes:
1		<input type="checkbox"/> EXCISION <input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> OTHER	<input type="checkbox"/>	
2		<input type="checkbox"/> EXCISION <input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> OTHER	<input type="checkbox"/>	
3		<input type="checkbox"/> EXCISION <input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> OTHER	<input type="checkbox"/>	
4		<input type="checkbox"/> EXCISION <input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> OTHER	<input type="checkbox"/>	
5		<input type="checkbox"/> EXCISION <input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> OTHER	<input type="checkbox"/>	
6		<input type="checkbox"/> EXCISION <input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> OTHER	<input type="checkbox"/>	
7		<input type="checkbox"/> EXCISION <input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> OTHER	<input type="checkbox"/>	
8		<input type="checkbox"/> EXCISION <input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> OTHER	<input type="checkbox"/>	

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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.