GEORGIA DERMATOPATHOLOGY ASSOCIATES

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Requisition No.

Telephone No. Client No.

☐ BILL DOCTOR ☐ BILL PATIENT ☐ BILL INSURANCE
INCLUDE OR ATTACH ALL BILLING INFO

CHART NO.	DATE COLLECTED	TIME COLLECTED	PHYSICIAN	ICD-9 CODE

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE)	SEX	DOB

PATIENT ADDRESS (INCLUDING APT. NO.)	CITY	STATE	ZIP	TELEPHONE NO.
				( )

BILLING/INSURANCE INFORMATION

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)	RESPONSIBLE PARTY SS #	EMPLOYER OF RESPONSIBLE PARTY
	___ – ___ – ____	

INSURANCE NAME	INSURANCE ADDRESS (INCLUDE CITY, STATE, ZIP CODE)

GROUP NO.	POLICY NO.	MEDICARE NO.	PATIENT SOCIAL SECURITY NO.
			___ – ___ – ____

DERMATOPATHOLOGY CONSULTATION REQUEST

CLINICAL HISTORY & PHYSICAL FINDINGS

	SPECIMEN SITE	CLINICAL DIAGNOSIS	SPECIAL REQUESTS (Margins, Stains, etc.)

REPORT HANDLING ☐ ROUTINE ☐ RUSH

☐ ADDITIONAL COPIES TO _____

☐ FAX TO

PHYSICIAN'S SIGNATURE