

Date Collected: ____/____/____ Time Collected: ____:____ ☐ AM ☐ PM

PATIENT INFORMATION (Items in tinted boxes are required)				PHYSICIAN / CLINIC INFORMATION	
Last Name		First Name		MI	
Street Address				Apt #	
City			State	Zip	
Patient DOB / /	Sex ☐ M ☐ F	Age	Social Security #		
Patient Phone #			Medical Record #		Referring Physician: _____ Copies To: _____

BILLING INFORMATION (Attach face sheet and/or front and back of insurance card in lieu of filling out billing information below)					
BILL TO: ☐ Insurance ☐ Medicare ☐ Medicaid ☐ Patient ☐ Physician/Clinic					
PRIMARY INSURED			SECONDARY INSURED		
Insurance Carrier	Policy #/Insured ID#	Group #	Insurance Carrier	Policy #/Insured ID#	Group #
Claims Address			Claims Address		
City	State	Zip	City	State	Zip
Policy Holder's Name	Policy Holder's DOB / /	Sex ☐ M ☐ F	Policy Holder's Name	Policy Holder's DOB / /	Sex ☐ M ☐ F
Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent		If Uninsured Patient ☐ Self Pay ☐ Indigent	Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent		If Uninsured Patient ☐ Self Pay ☐ Indigent
ICD-10 CODES: _____ / _____ / _____ / _____					

SPECIMEN / CLINICAL INFORMATION			
CLINICAL HISTORY _____			
SITE (LATERALITY)	COLLECTION METHOD	CLINICAL DIAGNOSIS	ICD-10 CODE
A ☐ L ☐ R	☐ PUNCH ☐ SHAVE ☐ EXCISION ☐ CURETTAGE	☐ CHECK MARGINS ☐ PREVIOUS BX # _____	
B ☐ L ☐ R	☐ PUNCH ☐ SHAVE ☐ EXCISION ☐ CURETTAGE	☐ CHECK MARGINS ☐ PREVIOUS BX # _____	
C ☐ L ☐ R	☐ PUNCH ☐ SHAVE ☐ EXCISION ☐ CURETTAGE	☐ CHECK MARGINS ☐ PREVIOUS BX # _____	
D ☐ L ☐ R	☐ PUNCH ☐ SHAVE ☐ EXCISION ☐ CURETTAGE	☐ CHECK MARGINS ☐ PREVIOUS BX # _____	
E ☐ L ☐ R	☐ PUNCH ☐ SHAVE ☐ EXCISION ☐ CURETTAGE	☐ CHECK MARGINS ☐ PREVIOUS BX # _____	
F ☐ L ☐ R	☐ PUNCH ☐ SHAVE ☐ EXCISION ☐ CURETTAGE	☐ CHECK MARGINS ☐ PREVIOUS BX # _____	

SPECIALTY TESTS / CONSULTATIONS	
☐ DIRECT IMMUNOFLUORESCENCE TEST (Submit in Michel's Fixative)	☐ SPECIAL HANDLING (Please specify) _____
☐ CONSULTATION / SECOND OPINION ☐ SPO	☐ OTHER _____

A Patient Name: _____ D.O.B.: _____ Site A: _____	B Patient Name: _____ D.O.B.: _____ Site B: _____	C Patient Name: _____ D.O.B.: _____ Site C: _____
D Patient Name: _____ D.O.B.: _____ Site D: _____	E Patient Name: _____ Site E: _____	F Patient Name: _____ D.O.B.: _____ Site F: _____