



American Dermatopathology Laboratory

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Biopsy Order Form

Date of Biopsy / /

Rush Case

Provider Name and Address	Lab Use
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Patient Information

Patient's Name		
Patient's Address	Patient DOB	Sex
SSN		
MRN	Account	Patient Phone

Billing and Insurance Information

Please include front and back copies of insurance cards.	Bill Patient <input type="checkbox"/> Bill Doctor <input type="checkbox"/>			
Primary Ins and Claims Address				
Insured	Insured's DOB	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>	ID	Group
Secondary Ins and Claims Address				
Insured	Insured's DOB	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>	ID	Group

Specimen Information

A - Bx Site	Clinical	Lab Use
<input type="checkbox"/> Shave <input type="checkbox"/> Punch <input type="checkbox"/> Exc <input type="checkbox"/> Other	<input type="checkbox"/> Previous biopsy <input type="checkbox"/> Check margins <input type="checkbox"/> Immunofluorescence <input type="checkbox"/> Duplicate slide	
<input type="checkbox"/> Shave <input type="checkbox"/> Punch <input type="checkbox"/> Exc <input type="checkbox"/> Other	<input type="checkbox"/> Previous biopsy <input type="checkbox"/> Check margins <input type="checkbox"/> Immunofluorescence <input type="checkbox"/> Duplicate slide	
<input type="checkbox"/> Shave <input type="checkbox"/> Punch <input type="checkbox"/> Exc <input type="checkbox"/> Other	<input type="checkbox"/> Previous biopsy <input type="checkbox"/> Check margins <input type="checkbox"/> Immunofluorescence <input type="checkbox"/> Duplicate slide	
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