Anatomical & Clinical Pathology
Bio-Path Medical Group
17330 Newhope Street, Suite A1
Fountain Valley, CA 92708
714-433-1330
FAX 714-755-2984

PATIENT INFORMATION

NAME LAST	FIRST	M.I.	DATE OF BIRTH	SEX M F	SOCIAL SECURITY NUMBER

STREET	APT. NO.	CITY	STATE	ZIP	PHONE ( )	CHART #	ICD-9 CODE

BILLING INFORMATION

BILL TO:

☐ PATIENT ☐ INSURANCE ☐ DOCTOR ☐ OTHER

RESPONSIBLE PARTY ☐ SELF ☐ SPOUSE ☐ PARENT

NAME:

MEDICARE No.	MEDICAL No.	(ATTACH CARD)	ISSUE DATE

INSURANCE INFORMATION

INSURANCE CARRIER

I.D. No. GROUP No.

CLAIMS ADDRESS

CITY STATE ZIP

REGULATIONS REQUIRE THAT ALL SPECIMENS BE LABELED WITH PATIENT'S NAME AND SPECIMEN SITE

DERMATOLOGY BIOPSY REQUEST

DATE OBTAINED _____

☐ SLIDE PREP ONLY
☐ INTERPRETATION

SPECIMEN 1 _____ SPECIMEN 4 _____

SPECIMEN 2 _____ SPECIMEN 5 _____

SPECIMEN 3 _____ SPECIMEN 6 _____

CLINICAL DIAGNOSIS	CLINICAL HISTORY

Rev. 05/00