

**PATIENT INFORMATION**

Patient Name (Last, First, MI)		Phone #	DOB	Gender M or F
Address		City	State	Zip

**PROVIDER INFORMATION**

Provider Name (Last, First, MI)	Provider NPI #	Referring Provider Code
Provider Signature	Provider Email Address	Provider Phone #

**INSURANCE INFORMATION**

 Bill to:  Patient  Medicare  Insurance

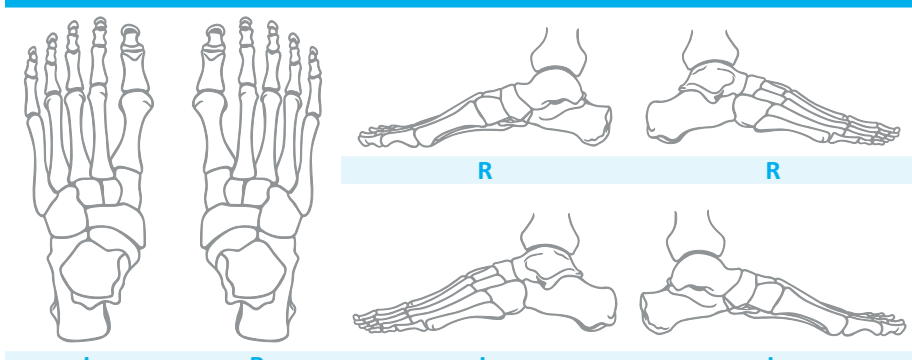
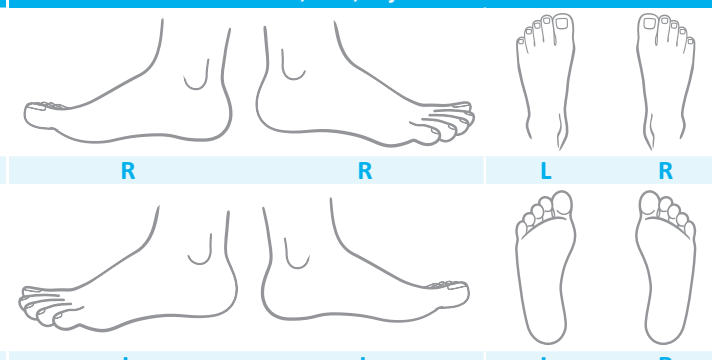
Insurance 1	ID #	Group #	Claims Mailing Address
Insurance 2	ID #	Group #	Claims Mailing Address
Date of Service	Date Received by Lab	Additional Notes	

**PATIENT CONSENT**

I hereby authorize you to submit my specimen to Histology Associates, Inc. I understand that there will be a separate pathology service billed to my insurance company and/or myself.

Patient Name (please print)	Patient Signature	Date
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Specimen Details	Test for Selected Options Below
<b>Specimen #1</b> : <input type="checkbox"/> Right <input type="checkbox"/> Left <span style="float: right;"><input type="checkbox"/> Biopsy <input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Shave</span>	<input type="checkbox"/> Bone Degeneration <input type="checkbox"/> Cyst <input type="checkbox"/> Nail Fungus: (KOH/PAS) <input type="checkbox"/> Nail Culture <input type="checkbox"/> Nail Malignancy <input type="checkbox"/> Skin Fungus <input type="checkbox"/> Skin Malignancy <input type="checkbox"/> Tumor <input type="checkbox"/> Ulcer <input type="checkbox"/> Verruca <input type="checkbox"/> Wound Culture w/ Sensitivity & ID* <input type="checkbox"/> Other: _____
Collection Date: _____ Date Received by Lab: _____ Pre-Operative Diagnosis: _____	
<b>Specimen #2</b> : <input type="checkbox"/> Right <input type="checkbox"/> Left <span style="float: right;"><input type="checkbox"/> Biopsy <input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Shave</span>	
Collection Date: _____ Date Received by Lab: _____ Pre-Operative Diagnosis: _____	
<b>Specimen #3</b> : <input type="checkbox"/> Right <input type="checkbox"/> Left <span style="float: right;"><input type="checkbox"/> Biopsy <input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Shave</span>	
Collection Date: _____ Date Received by Lab: _____ Pre-Operative Diagnosis: _____	

Skeletal	Nail, Skin, Soft Tissue
	

**REMARKS**