Practice Name _______________
Practice Street _______________
City ______ State ____ Zip______
Phone ____________________

Ph: 847-996-1030 Fax: 847-996-0791

Patient				**Billing** [ ] Insurance [ ] Account [ ] Patient
Name (Last, First)				Responsible party (Last, First) [ ]Self [ ]Child [ ]Spouse [ ]Other ________________
Patient ID or SSN		Office MRN		Address
Date of Birth	Male [ ] Female [ ]	Collection Date		City | State | Zip
Send additional report to:		Fax #		Patient Phone # ( ) -
ICD10				Medicare ID# with Suffix
				Primary Insurance Name and Plan
Request	[√] Slide Consultation [ ] Slide Preparation [ ] Complete Service			Policy ID # Group ID
Specimen Site(s)				**Please attach a copy of front and back of insurance card and patient demographic information sheet**

Specimen Site	Procedure	Margins	Clinical Impression / Information
1 [ ] DIF [ ] PAS [ ] Aerobic culture [ ] Anaerobic culture [ ] Fungal culture	[ ] Biopsy [ ] Curetting [ ] Punch [ ] Shave [ ] Excision	☐	
2 [ ] DIF [ ] PAS [ ] Aerobic culture [ ] Anaerobic culture [ ] Fungal culture	[ ] Biopsy [ ] Curetting [ ] Punch [ ] Shave [ ] Excision	☐	
3 [ ] DIF [ ] PAS [ ] Aerobic culture [ ] Anaerobic culture [ ] Fungal culture	[ ] Biopsy [ ] Curetting [ ] Punch [ ] Shave [ ] Excision	☐	
4 [ ] DIF [ ] PAS [ ] Aerobic culture [ ] Anaerobic culture [ ] Fungal culture	[ ] Biopsy [ ] Curetting [ ] Punch [ ] Shave [ ] Excision	☐	
5 [ ] DIF [ ] PAS [ ] Aerobic culture [ ] Anaerobic culture [ ] Fungal culture	[ ] Biopsy [ ] Curetting [ ] Punch [ ] Shave [ ] Excision	☐	
6 [ ] DIF [ ] PAS [ ] Aerobic culture [ ] Anaerobic culture [ ] Fungal culture	[ ] Biopsy [ ] Curetting [ ] Punch [ ] Shave [ ] Excision	☐	

Physician Signature:	Date:

28100 N. Ashley Circle, suite 106, Liberyville IL 60048