ATLANTIC PATHOLOGY

SURGICAL HISTOLOGY REQUISITION FORM

PATIENT INFORMATION

Last Name | First Name | M.I.

Date of Birth / / | Sex M | F | Specimen Date / / | Record Number | Patient Phone Number ( )

Street Address | Apt. #

City | State | Zip

INTERNAL USE ONLY

PHYSICIAN'S INFORMATION

Physician's Name | Licence Number

Physician's Signature

BILLING INFORMATION

Attach copy of all insurance I. D. Cards (front and back, please)

Bill To: ○ Patient ○ Doctor ○ Insurance

Principal Insured DOB:

Principal Insured Name: | Relationship to Patient

Insurance Name | Contract # | Group #

○ Medicare patient reviewed and signed advanced beneficiary notice for non-covered services

Diagnosis Code(s) | Patient Signature

HISTORY AND CLINICAL DIAGNOSIS

SPECIMENS

1. ______________________

2. ______________________

3. ______________________

4. ______________________

5. ______________________

6. ______________________

SPECIFIC QUESTIONS / INSTRUCTIONS FOR PATHOLOGY LAB

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