INTERNAL USE ONLY

ATLANTIC PATHOLOGY
PODIATRIC DIVISION

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PATIENT INFORMATION

Last Name	First Name	M.I.

Date of Birth	Sex	Record No.	Age	Patient Phone Number
/ /	M | F			( )

Address	City	State	Zip

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 #

Patient Signature:

I authorize my physician to provide any necessary information to the laboratory for the sole purpose of billing my medical insuranceplan. I accept that I will be held responsible for any procedure payment that my medial insurance plan my no cover.

CLINICAL INFORMATION

Service Date	Nature of Specimen

Previous Antifungal: ○ ORAL ○ TOPICAL

Test to be performed: ○ PAS ○ GMS ○ KOH ○ Culture ○ Other: _____

CLINICAL HISTORY

R Dorsal L R Lateral L R Plantar L R Medial L

R. 6-2010

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