Clinician

Address

Phone #:

Fax#:

Department of Dermatology
Dermatopathology Section
222 East 41st street 25th Floor
New York, NY 10017
Ph: (212)263-7250 Fax: (212)263-1683

FOR OFFICE USE ONLY

SLIDE CONSULTATION REQUEST FORM

Patient Information

LAST NAME	FIRST NAME	M.I.

AGE	DATE OF BIRTH	❑ M ❑ F	HOME PHONE #	BUSINESS PHONE #	MEDICAL RECORD #
	/ /				

ADDRESS

CITY, STATE, ZIP CODE

BILLING INFORMATION

PRIMARY INSURANCE: ☐ Medicare ☐ Insurance ☐ Self Pay ☐ Bill Client

Insurance Name: _____ Policy Holder Name: _____

Policy # _____ Group # _____

Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Ins. Plan Address _____

Secondary Ins. _____ Policy # _____ Group # _____

CLINICAL INFORMATION

LAB USE ONLY

DATE

BIOPSY SITE

OUTSIDE SLIDE #

CLINICAL DESCRIPTION AND IMPRESSION

REFERRING CLINICIAN

PRINT: _____ SIGNATURE _____

DC 11/6/2020