



4800 SW 35th Dr., Gainesville, FL 32608



Complete For All Patients

Patient Name (Last)		(First)	(M.I.)	Patient ID #		Date of Birth / /		Sex M F
Street Address			City		State	Zip	Patient Phone	
Ordering Physician		Duplicate Report Sent To:			Bill To: <input type="checkbox"/> Client <input type="checkbox"/> Patient <input type="checkbox"/> Insurance <input type="checkbox"/> Mcare/Mcaid			

Complete To Bill Third Party

Primary Insurance Name		Address		City		State	Zip
ID/Member #	Group #		Responsible Party/Insured Employer			DOB	
Secondary Insured Name		Address		City		State	Zip
ID/Member #	Group #		Responsible Party/Insured Employer			DOB	
Patient relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent							

Physicians

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ICD-9	ICD-9	ICD-9	ICD-9	

Collection Date: ___/___/___

Sections for Margins: Specimen
(Please circle appropriate letters)

A B C D E F G H

Patient History: _____

Punch (P) / Shave (S) / Excision (E)

Biopsy Site

Clinical Diagnosis

P S E A. _____
 P S E B. _____
 P S E C. _____
 P S E D. _____
 P S E E. _____
 P S E F. _____
 P S E G. _____
 P S E H. _____

A. _____
 B. _____
 C. _____
 D. _____
 E. _____
 F. _____
 G. _____
 H. _____

Special Requests: _____

PERMISSION FOR TREATMENT AND AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:

Authorization is given to University of Florida Diagnostic Reference Laboratories to release any information including examination, diagnosis and treatment, to my insurance carrier.

I request my insurance carrier to pay University of Florida Diagnostic Reference Laboratories benefits due me related to my pending claim for medical and surgical services.

My signature is on the front side of this form.