DERMATOPATHOLOGY ASSOCIATES, PLLC

BILLY L. WALKER, M.B.A., M.D. • JENNIFER S. SCHULMEIER, M.D. • BUU T. DUONG, M.D.
Phone: (601) 362-9851 • 1-800-270-0055 • Fax: (601) 982-9025
JACKSON, MS

From: Dr.

SPECIMEN DATE: ______________________
PATIENT FIRST NAME: ______________________
PATIENT LAST NAME: ______________________
SOCIAL SECURITY NUMBER: ______________________
SEX: __________ RACE: __________ AGE: __________
DATE OF BIRTH: ______________________
RESPONSIBLE PARTY: ______________________
RELATION TO PATIENT: ______________________
ADDRESS: ______________________
CITY: ______________ STATE: ______ ZIP: ______
HOME PHONE NUMBER: ______________________
PLACE OF EMPLOYMENT: ______________________
WORK PHONE NUMBER: ______________________

INSURANCE INFORMATION

Medicare No.: ______________________
Medicaid No.: ______________________
Or
Primary Insurance Co.: ______________________
Company Address: ______________________
____
Name of Insured: ______________________
Relationship of Patient to Insured: ______________________
Policy ID #: ______________________ Grp #

Secondary Insurance Co.: ______________________
Company Address: ______________________
____
Name of Insured: ______________________
Relationship of Patient to Insured: ______________________
Policy ID #: ______________________ Grp #

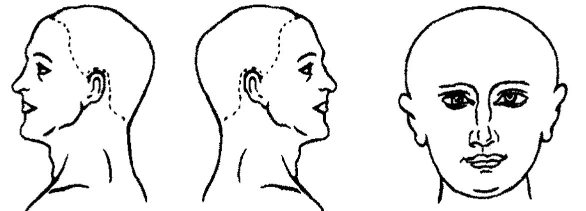
For Medicare and other insured patients: I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediates or carriers or any other governmental agency or insurance carrier responsible for payment any information needed for this or related Medicare or other claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the above.

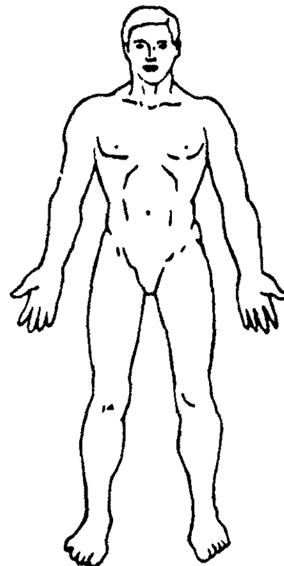
I authorize and give my consent to send this specimen to Dermatopathology Associates, PLLC. These doctors are specialized in the interpretation of skin tissue specimens and will render a separate charge to me for their services.

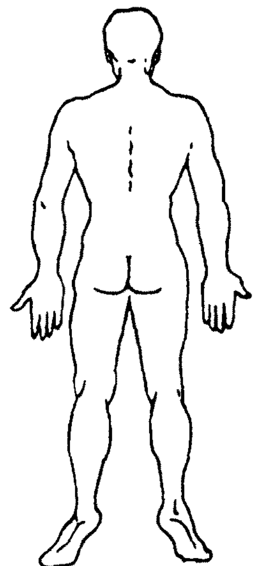
PATIENT'S SIGNATURE ______________________

CLINICAL HISTORY, OPERATIVE SITE & CLINICAL DIAGNOSIS

MARK SITE(S)







☐ FRONT ☐ BACK

1 - **FORWARD WITH SPECIMEN**