ACADEMY OF SKIN PATHOLOGY
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Laboratory Director: Xiao-Dong Wang, MD, FCAP, FASD

Physician Name: **Office Address:** **Phone:**

Patient Name: **Social Security Number:**
Date of Birth: **Sex:** M F
Guarantor Name: **Address:**
Relation: **Phone:**

Billing Information: Patient Insurance Physician Medicare# (Copy of Insurance Card)

Date of Biopsy: **Number of Biopsies:** **Source:** Skin Nail Oral Others

Type of Biopsy:	Body Site:	Clinical History	Impression	Check Margin	Prior Biopsy
A. Punch Shave Excision Frozen DIF	R/L			Y/N	Y/N
B. Punch Shave Excision Frozen DIF	R/L			Y/N	Y/N
C. Punch Shave Excision Frozen DIF	R/L			Y/N	Y/N
D. Punch Shave Excision Frozen DIF	R/L			Y/N	Y/N
E. Punch Shave Excision Frozen DIF	R/L			Y/N	Y/N

Physician Signature:

I authorize any holder of medical or other information about me to release to the Social security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original request payment of medical insurance benefits either to myself or the party who accept assignment.

Patient Signature: **Date:**