LPMG
LAGUNA PATHOLOGY MEDICAL GROUP
Barr Dermatopathology
division of Newport Harbor Pathology Medical Group

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Federal tax ID#: 95-265-9212

Patient Information

Last Name

First Name

Date of Birth **Sex**

Address

City/State/Zip

Phone:

Collection Date:

_____ / ____ / _____

STATE AND FEDERAL REGULATIONS REQUIRE YOU TO PROVIDE THE PATIENT'S DEMOGRAPHICS AND INSURANCE INFORMATION, INCLUDING A COPY OF THEIR INSURANCE CARD. PER CAP GUIDELINES. CLINICAL INFORMATION MUST ALSO BE PROVIDED.

Doctor: _____

Phone: _____

Physician Signature: _____

☐ Send copy of report to additional physician(s):

_____

☐ Fax to: _____

Patient Billing Information:

☐ Copy of Insurance Card

☐ Medicare

☐ Bill Client

☐ Self Pay

☐ Patient Demographics Attached

Specimen Information

☐ **STAT**

☐ SLIDE CONSULTATION: Provide reason for the consultation or attach pathology report.

☐ PREVIOUSLY BIOPSIED? Provide Case #: _____ and attach report (if not LPMG.)

Material Enclosed

Number of Slides: _____

Number of Blocks: _____

Site	Specimen # (if applicable)	Clinical Information
A.		***If derm, indicate if** ☐ Punch ☐ Base tx ☐ Shave ☐ Excision
B.		***If derm, indicate if** ☐ Punch ☐ Base tx ☐ Shave ☐ Excision
C.		***If derm, indicate if** ☐ Punch ☐ Base tx ☐ Shave ☐ Excision
D.		***If derm, indicate if** ☐ Punch ☐ Base tx ☐ Shave ☐ Excision
E.		***If derm, indicate if** ☐ Punch ☐ Base tx ☐ Shave ☐ Excision

88305/927 x____ 88312/425 x_____ 88302/431 X_____ 88313/478 x_____ 88321/321 X_____ 88304/926 X_____ MD:_____