UCI Health Dermatopathology

PATIENT DEMOGRAPHICS — REQUIRED			CLINICIAN INFORMATION *(Please Print)*
NAME (FIRST)	**(LAST)**	**(MIDDLE INITIAL)**	
DATE OF BIRTH (MM/DD/YYYY)	**GENDER** ☐ M ☐ F ☐ Other:_____		
PATIENT ADDRESS (NO PO BOX)			
CITY, STATE, ZIP CODE			
PATIENT PHONE NUMBER			
BILL TO: ☐ PATIENT ☐ INSURANCE *(Attach copy of card)*	☐ MEDICARE ☐ PHYSICIAN	☐ MEDICAID ☐ OTHER	**DATE OF SERVICE:**

SPECIMEN TYPE *(Check one)* *(USE EXTRA SHEETS FOR ADDITIONAL SPECIMENS)*

SPECIMEN (A) ☐ Punch ☐ Shave ☐ Excision ☐ Alopecia Protocol ☐ Slide Consult ☐ Direct IF (Skin/Mucosa)	**SITE:** **CLINICAL INFORMATION:** **DDX:**
SPECIMEN (B) ☐ Punch ☐ Shave ☐ Excision ☐ Alopecia Protocol ☐ Slide Consult ☐ Direct IF (Skin/Mucosa)	**SITE:** **CLINICAL INFORMATION:** **DDX:**
SPECIMEN (C) ☐ Punch ☐ Shave ☐ Excision ☐ Alopecia Protocol ☐ Slide Consult ☐ Direct IF (Skin/Mucosa)	**SITE:** **CLINICAL INFORMATION:** **DDX:**
SPECIMEN (D) ☐ Punch ☐ Shave ☐ Excision ☐ Alopecia Protocol ☐ Slide Consult ☐ Direct IF (Skin/Mucosa)	**SITE:** **CLINICAL INFORMATION:** **DDX:**

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