

DYSON MOSELEY DERMATOPATHOLOGY LAB

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PATIENT INFORMATION			
Last Name		First Name	
Social Security Number		Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Address		City	Zip Phone

PHYSICIAN INFORMATION			
Name		Address	
City		Zip	
Phone		Fax:	
		NPI:	

BILLING INFORMATION (Please fill out the information below OR attach front/back copy of insurance cards.)				
Subscriber Name/Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other		Subscriber Name/Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other		
Primary Insurance Company Name		Secondary Insurance Company Name		
Primary Insurance Company Address		Secondary Insurance Company Address, City, State, Zip		
Primary Insurance City, State, Zip		Member ID		
Employer Name		Employer Name		

Self Pay (Please be sure patient contact information is correct and that patient is aware of separate lab charges.)

SPECIMEN INFORMATION

() BIOPSY (DATE): _____ () PREVIOUS BIOPSY INFO: _____

SITE:	Specimen Type (Circle One):	HISTORY/CLINICAL IMPRESSION OF LESION(S):
A.	PUNCH BX SHAVE BX SNIP BX INCISIONAL BX EXCISION EXCISIONAL BX CHECK MARGINS ALOPECIA SECTIONS SLIDE CONSULT Other: _____	
B.	PUNCH BX SHAVE BX SNIP BX INCISIONAL BX EXCISION EXCISIONAL BX CHECK MARGINS ALOPECIA SECTIONS SLIDE CONSULT Other: _____	
C.	PUNCH BX SHAVE BX SNIP BX INCISIONAL BX EXCISION EXCISIONAL BX CHECK MARGINS ALOPECIA SECTIONS SLIDE CONSULT Other: _____	
D.	PUNCH BX SHAVE BX SNIP BX INCISIONAL BX EXCISION EXCISIONAL BX CHECK MARGINS ALOPECIA SECTIONS SLIDE CONSULT Other: _____	

For additional specimens please attach a second form.