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FALL RIVER, MA 02720

ACCOUNT INFORMATION	SPECIMEN DATE	SURGICAL NUMBER
	RECEIVED DATE	
SEND COPY OF REPORT TO:	SS#	

PATIENT'S NAME (Last)	(First)	(M.I.)	PT'S DATE OF BIRTH	AGE	GENDER

BILLING DATA **RESPONSIBLE PARTY / SUBSCRIBER INFORMATION** BILL INSURANCE ❑ BILL PATIENT ❑ *Please Complete All Information*

LAST NAME	FIRST	DATE OF BIRTH	GENDER	TELEPHONE
STREET	CITY	STATE		ZIP CODE

SECOND RESPONSIBLE PARTY NAME DATE OF BIRTH

MEDICARE	CLAIM #	**MEDEX**	ID #
BC/BS	POLICY STATE	SUBSCRIBER'S ID #	GROUP #
MEDICAID	PROGRAM STATE	RECIPIENT'S ID# (For Massachusetts record 10-digit RID # only)	
OTHER INSURANCE AND HMO	INSURANCE NAME ______ (& ADDRESS) ______ POLICY ID # MEMBER # GROUP #		

REQUIRED FOR ALL INSURANCE COVERAGE

PATIENT'S RELATION TO INS. SUBSCRIBER

1 ❑ SELF 2 ❑ SPOUSE 4 ❑ CHILD 5 ❑ OTHER

By signing below, I understand that I hereby authorize University Pathologists Diagnostics, LLC. to disclose my medical information for purposes of treatment, to seek payment from third parties for such treatment, and to generally carry on health care operations.

Signature ______ Date ______

PREVIOUS PATHOLOGY RESULTS AND DATE:

OBS / GYN SPECIMEN

PREVIOUS PAP RESULTS AND DATE:

HORMONE THERAPY? ❑ YES ❑ NO

L.M.P.

CLINICAL DIAGNOSIS AND / OR HISTORY

TISSUE SOURCE:

______

AUTHORIZATION SIGNATURE