DERMATOPATHOLOGY ASSOCIATES, PLLC

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JACKSON, MS

From: Dr.

SPECIMEN DATE: _____
PATIENT FIRST NAME: _____
PATIENT LAST NAME: _____
SOCIAL SECURITY NUMBER: _____
SEX: _____ RACE: _____ AGE: _____
DATE OF BIRTH: _____
RESPONSIBLE PARTY: _____
RELATION TO PATIENT: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE NUMBER: _____
PLACE OF EMPLOYMENT: _____
WORK PHONE NUMBER: _____

INSURANCE INFORMATION

Medicare No.: _____
Medicaid No.: _____
Or
Primary Insurance Co.: _____
Company Address: _____
_____
Name of Insured: _____
Relationship of Patient to Insured: _____
Policy ID #: _____ Grp # _____

Secondary Insurance Co.: _____
Company Address: _____
_____
Name of Insured: _____
Relationship of Patient to Insured: _____
Policy ID #: _____ Grp # _____

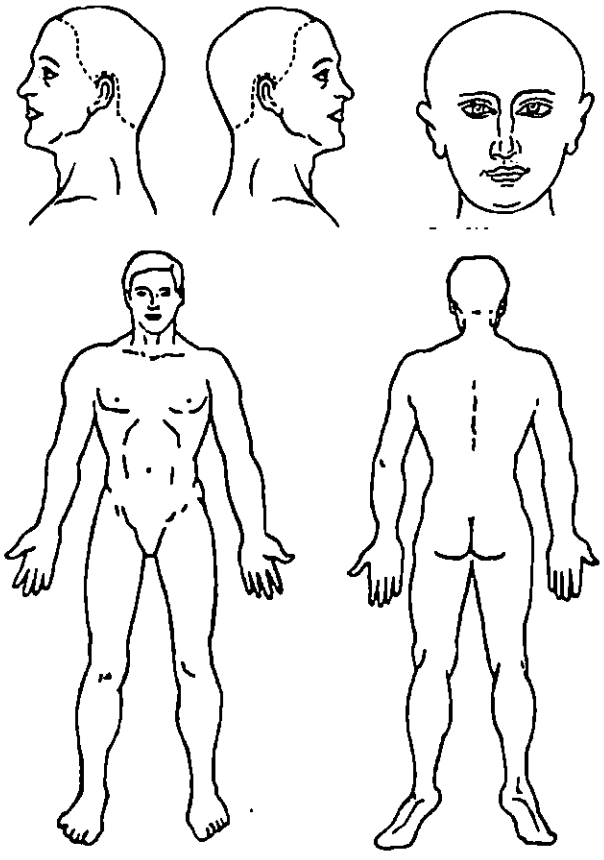
For Medicare and other insured patients: I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediates or carriers or any other governmental agency or insurance carrier responsible for payment any information needed for this or related Medicare or other claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the above.

I authorize and give my consent to send this specimen to Dermatopathology Associates, PLLC. These doctors are specialized in the interpretation of skin tissue specimens and will render a separate charge to me for their services.

PATIENT'S SIGNATURE _____

CLINICAL HISTORY, OPERATIVE SITE & CLINICAL DIAGNOSIS

MARK SITE(S)



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1 - FORWARD WITH SPECIMEN