



**EVERGREEN**  
DERMATOPATHOLOGY

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2110 North Molter Road  
Suite 112  
Liberty Lake, WA 99019

<b>Accession Number (Lab Only)</b>	
<b>COLLECTION</b>	
DATE	TIME

**PATIENT INFORMATION**

LAST NAME	FIRST NAME	MI	SEX Male Female Unknown
DATE OF BIRTH (REQUIRED)	SSN	PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

**AUTHORIZING PROVIDER**

CLINIC NAME			
CLINICIAN NAME	CLINICIAN PHONE	CLINICIAN FAX	
CLINIC ADDRESS	CITY	STATE	ZIP CODE

**CC PROVIDER**

PROVIDER NAME	PROVIDER PHONE	PROVIDER FAX	
PROVIDER ADDRESS	CITY	STATE	ZIP CODE

**BILL TO**

CHECK ONE: INSURANCE PATIENT PHYSICIAN (ATTACH INFORMATION)			
POLICY HOLDER NAME		POLICY HOLDER ADDRESS	
PRIMARY INSURANCE POLICY NAME			
POLICY HOLDER DOB	POLICY #	GROUP #	

**SPECIMEN INFORMATION**

	ANATOMIC SITE	PROCEDURE	CLINICAL HISTORY AND DIAGNOSIS
A		SHAVE PUNCH EXCISION OTHER MEASUREMENT:	
B		SHAVE PUNCH EXCISION OTHER MEASUREMENT:	
C		SHAVE PUNCH EXCISION OTHER MEASUREMENT:	
D		SHAVE PUNCH EXCISION OTHER MEASUREMENT:	
E		SHAVE PUNCH EXCISION OTHER MEASUREMENT:	

**ADDITIONAL COMMENTS**

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