



# FINAN TEMPLETON

DERMATOPATHOLOGY ASSOCIATES

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File #: \_\_\_\_\_

Date of Biopsy: \_\_\_\_\_  
MO / DAY / YEAR

Social Sec. #: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_  M  F  
FIRST M.I. LAST

Patient Address: \_\_\_\_\_ Age: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
STREET

\_\_\_\_\_ Race: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
CITY STATE ZIP MO / DAY / YEAR

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Responsible Party: \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Site:	✓ Margins	Clinical Data / Impression – Pertinent Previous Path:
A	<input type="checkbox"/>	
B	<input type="checkbox"/>	
C	<input type="checkbox"/>	

\_\_\_\_\_  
CLINICIAN OFFICE LOCATION

For Lab Use Only  
**DERMATOPATHOLOGY  
REQUISITION**