



**PATIENT INFORMATION**

LAST NAME  FIRST NAME

DATE OF BIRTH  SEX (M/F)  PHONE

ADDRESS / CITY / STATE / ZIP

**ORDERING PROVIDER**

PROVIDER / CLINIC NAME  NPI #

ACCOUNT #  COLLECTION DATE  COLLECTION TIME

**BILLING / INSURANCE**

Insurance     Client Bill     Patient Self-Pay

INSURANCE CARRIER  MEMBER ID

**TEST SELECTION**

<input type="checkbox"/> Respiratory PCR	<input type="checkbox"/> GI Pathogen PCR	<input type="checkbox"/> UTI / Wound PCR
<input type="checkbox"/> Women's Health PCR	<input type="checkbox"/> STI Panel	<input type="checkbox"/> Nail / Onychomycosis
<input type="checkbox"/> CBC	<input type="checkbox"/> Comprehensive Metabolic	<input type="checkbox"/> Lipid Panel
<input type="checkbox"/> Hemoglobin A1c	<input type="checkbox"/> Thyroid (TSH/T3/T4)	<input type="checkbox"/> Toxicology Screen

**DIAGNOSIS CODES (ICD-10)**

ICD-10 CODES

PROVIDER SIGNATURE  DATE