# Lab Form

Type of Lab:_____

First Name: _____

Middle Name: _____

Last Name: _____

Gender: _____

Present Address:_____

City: _____ State: _____

Zip Code: _____ Country: _____

Phone: _____ Email: _____

PAYMENT INFO:

Responsible Party-Full Name: _____

Responsible Party-Phone: _____

Payment Type:

___ Check ___ Money ___ Credit Card

Credit Card Number: _____

Name on Card: _____

Expiration Date: _____ (MM/YY) Security Code: _____

Billing Address: _____

(City, State & Zip Code) _____

INSURANCE INFORMATION:

Primary Insurance Company: _____

Claims Address: _____

(City, State & Zip): _____

Insurance Co. Phone: _____

Subscriber Full Name: _____

Subscriber ID/Medicare #: _____

Social Security #: _____

Date of Birth: _____(MM/DD/YY)

Relation to Patient: ___Self ___Other: _____