



**Cytogenetics Laboratory**  
 75 Francis Street, Amory 3, Room 151  
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**INSTITUTIONAL PATIENT REGISTRATION & BILLING INFORMATION FORM**  
 Please complete ENTIRE form and fax to: 617-975-0945

**PATIENT INFORMATION:**

Name: _____	Hospital / Lab Control # _____
Address: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
City, State: _____	DOB: ____ / ____ / ____
Zip: _____ Home Phone: _____	SSN: ____ / ____ / ____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Maiden Name: _____
E.Mail Address: _____	Mother's Maiden Name: _____
Primary Care MD: _____	Phone: _____
Address: _____	City, State, Zip: _____

**ORDERING MD INFORMATION:**

Ordering MD: _____
Institution: _____
Address: _____
City, State, Zip: _____ E.Mail Address: _____
Phone: _____ Fax: _____ Pager: _____
UPIN #: _____ MA Lic #: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F DOB: ____ / ____ / ____ Specialty: _____

**BILLING INFORMATION:**

Billing Contact: _____
Institution: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

**Please note that the Institution will be billed for work performed.**