

**NOTE: Bolded Areas Must Be Completed**

**SURGERY SCHEDULING FORM**

Patient/legal guardian given written "Patient Rights and Responsibilities" on \_\_\_\_\_ by \_\_\_\_\_ .  
Date before surgery Initials

Date of Surgery \_\_\_\_\_ Surgeon \_\_\_\_\_

Diagnosis: \_\_\_\_\_ **ICD-9 Codes:** \_\_\_\_\_

Anesthesia: GEN MAC TIVA Block IVSed Local Other: \_\_\_\_\_

Start time \_\_\_\_\_ Duration \_\_\_\_\_

**CPT** \_\_\_\_\_

**PROCEDURE** (Consent to Read) \_\_\_\_\_

Labwork Required: \_\_\_\_\_

Special Request / Special Equipment \_\_\_\_\_

C-Arm Required: Y N      23 Hour Stay Required (Tuesday-Thursday Only): Y N  
\*Pt can not stay overnight if 65 years or older or on Medicare

Patient Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone HM ( ) \_\_\_\_\_ Phone WK ( ) \_\_\_\_\_ Phone Cell ( ) \_\_\_\_\_

DOB \_\_\_\_\_ Sex \_\_\_\_\_ Patient SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer \_\_\_\_\_ Emergency Contact \_\_\_\_\_

Parent Name ( if patient is a minor) \_\_\_\_\_

**Primary Insurance** ATTACH COPY OF INS. CARD      **Secondary Insurance** ATTACH COPY OF INS. CARD

Carrier \_\_\_\_\_ Carrier \_\_\_\_\_

Insurance company \_\_\_\_\_ Insurance company \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

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

Subscriber name \_\_\_\_\_ Subscriber name \_\_\_\_\_

Relationship \_\_\_\_\_ Relationship \_\_\_\_\_

DOB \_\_\_\_\_ SS # \_\_\_\_\_ DOB \_\_\_\_\_ SS # \_\_\_\_\_

In case we have any questions, Scheduled By: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Signature: \_\_\_\_\_