

CAMPUS SURGERY CENTER

SURGERY SCHEDULING FORM

Date: _____ Time: _____ AnesType: _____ OR Time: _____ Surgeon _____ Assistant _____ <input type="checkbox"/> Diabetic <input type="checkbox"/> Weight > 300 lbs. _____ PRE-OP TESTS <input type="checkbox"/> None <input type="checkbox"/> EKG <input type="checkbox"/> Labs _____	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;">Patient _____</td> <td style="width:20%;">Primary Language _____</td> <td style="width:10%;">Male</td> <td style="width:10%;">Female</td> </tr> <tr> <td style="text-align: center;">Last First Middle Initial</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Date of Birth _____</td> <td>S.S.# _____</td> <td colspan="2">Marital Status M S D W</td> </tr> <tr> <td>Address _____</td> <td colspan="3">Home Phone: _____</td> </tr> <tr> <td>City/State/Zip _____</td> <td colspan="3">Work Phone: _____</td> </tr> <tr> <td>Employer _____</td> <td colspan="3">Cell Phone: _____</td> </tr> <tr> <td>Procedure Description</td> <td colspan="3">CPT: _____</td> </tr> <tr> <td></td> <td colspan="3">CPT: _____</td> </tr> <tr> <td></td> <td colspan="3">CPT: _____</td> </tr> <tr> <td></td> <td colspan="3">CPT: _____</td> </tr> </table>	Patient _____	Primary Language _____	Male	Female	Last First Middle Initial				Date of Birth _____	S.S.# _____	Marital Status M S D W		Address _____	Home Phone: _____			City/State/Zip _____	Work Phone: _____			Employer _____	Cell Phone: _____			Procedure Description	CPT: _____				CPT: _____				CPT: _____				CPT: _____		
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Diagnosis Description	ICD-9: _____
	ICD-9: _____
	ICD-9: _____
	ICD-9: _____

INSURANCE COMPANY - PRIMARY	
I.D. # _____	Grp #: _____
Phone: _____	

Insurance Information – Primary (If other than patient)	
SUBSCRIBER _____	Relationship _____
Address _____	
Phone (If different _____)	DOB: _____ S.S.#: _____
SUBSCRIBER Employer _____	Work Phone: _____
Address _____	

INSURANCE COMPANY - SECONDARY	
I.D.# _____	Grp #: _____
Phone: _____	

SPECIAL EQUIPMENT/ INSTRUMENT/ IMPLANT REQUEST
Position: <input type="checkbox"/> Prone <input type="checkbox"/> Supine <input type="checkbox"/> Beach Chair <input type="checkbox"/> Lateral Other: _____

WORKERS' COMP INFO.	Adjuster: _____
DOI: _____	CLM#: _____
Auth'd By: _____	
Date of Auth: _____	FAX#: _____
Financial Disclosure: _____	Date: _____