SURGERY SCHEDULING FORM

Is this the patient's first visit to our facility?

□ Yes □ No

Arkansas Valley Surgery Center
Ph: 719-275-6433 Fax: 719-275-7009

PATIENT NAME _____ DOB ____/____/_____ SEX: M / F

ADDRESS _____ CITY _____ ZIP _____

PHONE: Home _____ Mobile _____ Work _____

PATIENT'S SSN# _____ INSURED'S SSN# _____ INSURED'S DOB_____

PROCEDURE DATE _____ REQUESTED TIME _____:_____ LENGTH OF PROC. _____

INSURED'S EMPLOYER _____ PHONE _____

RESPONSIBLE PARTY:_____

Insurance Information Attach insurance card(s) copy (front and back)

Insurance Carrier _____ Phone _____
Address _____
ID# _____ Policy # _____ Group # _____

Insurance Carrier _____ Phone _____
Address _____
ID# _____ Policy # _____ Group # _____

Pre-authorization □ Pre-authorization not required / **Workers' Compensation - DOI _____**

Obtained for surgery center?	Name of Office Staff Authorizing	Insurance Carrier Authorizing Agent	Authorization #	Comments
□ Yes □ No				

DIAGNOSIS _____

ICD 9 CODE _____

CPT CODE _____

SURGICAL PROCEDURE (S):_____

_____

PHYSICIAN: DR_____ASSISTANT _____

TYPE OF ANESTHESIA: □ General □ MAC □ CS □ Local □ Bier Block □ Other _____

Pre Operative Labs: YES NO if yes what _____

Special equipment needed: □ c-arm □ Other _____