CAMPUS SURGERY CENTER, LLC, 901 Campus Drive, Suite 102, Daly City, CA 94015 (650) 991-2000 / FAX (408) 402-7016
▪ Surgery Scheduling DIRECT PHONE (650) 289-1656 ▪ DIRECT FAX (415) 919-5803

SURGERY SCHEDULING FORM

EMAIL:

Date:
Time:
AnesType:
OR Time:
Surgeon
Assistant
☐ **Diabetic** ☐ **Weight > 300 lbs.** _____
PRE-OP TESTS ☐ **None** ☐ **EKG**
☐ **Labs**

Patient _____ **Male** **Female**
Last, First, Middle Initial
Date of Birth _____ **S.S.#** _____ **Martial Status** **M** **S** **D** **W**
Address _____ **Home Phone:**
City/State/Zip _____ **Work Phone:**
Employer _____ **Cell Phone:**
CONSENT TO READ (NO ABBREVIATIONS – PLEASE BE EXACT)

CPT Code(s):

Diagnosis
ICD-10:
ICD-10:
ICD-10:
ICD-10:

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: ☐ Prone ☐ Supine ☐ Beach Chair ☐ Lateral Other:

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