SURGERY/PROCEDURE SCHEDULING FORM

Information must be faxed / received by the procedural department and admitting no later than 72 hours prior to the procedure. Admitting Fax: 409-853-5239 Surgery Fax: 409-853-5973

Surgery Reservation for:
Dr.________________________________Assistant________________________

Patient Legal Name____________________________________Age_____DOB_________
First Initial Last

Address____
Street City State ZIP

Phone H_______________W________________C______________Other________________
SS#______________________Gender: ❑M ❑F Latex Allergy: ❑Yes ❑No Weight________________
❑Post Op Admission ❑Outpatient ❑Inpatient/ Room # ________________ Day before Adm.________________

Procedure____

____

____

Pre-Op Diagnosis____
Surgery/Procedure Date_____________Start Time______________Time Required________________________
Date Faxed_______________ICD-9 Code***______________CPT Code***________________________*****Required**
Implants Type____Brand___________________________________
Vendor Name________________________________Contact #______________________________________

Special Instruments:____
Special Equipment: ❑CArm ❑Cell Saver Other____

Anesthesia: ❑Local ❑Moderate Sedation ❑MAC ❑General ❑Spinal/Regional
Anesthesia Group (if indicated)______________________Special Request________________________________

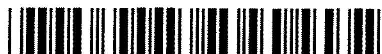
Insurance Information – Person Financially Responsible
Name of Insured____Insured S/S #_________________________
Relationship to Patient___________________________________DOB_____________________________________

Copies of patient insurance cards (Front & Back) OR complete information below ***Required
Primary Insurance________________Policy #____________________________Group #______________________
Primary Insurance Phone #____
Secondary Insurance________________Policy #__________________________Group #________________________
Secondary Insurance Phone #____

Authorization & Pre-Certification #___________________________________Expiration Date____________________
Self Pay ❑Yes ❑No
ICA Claim ❑Yes ❑No Date of Injury__________________ICA Carrier____
ICA Carrier Address____Phone__________________________

Required Patient Data to be Faxed with Scheduling Form <u>72 HOURS BEFORE DAY OF SURGERY</u>

1. Surgeon's Orders Faxed with Reservation: ❑Yes ❑No ❑To Follow
2. Surgical PreOps to be done at facility: ❑Yes ❑No If No, where?____
3. Clearance (if needed): ❑Medical ❑Cardiac ❑Pulmonary Dr. Name:______________________________________
4. History & Physical Attached: ❑Yes ❑No ❑Will be done day of surgery
5. Completed Informed Consent Attached: ❑Yes ❑No ❑Will be done day of surgery



Account Number:	MR Number:
Patient Name:	
Admit Date:	

2555 Jimmy Johnson Blvd. - Port Arthur - Texas 77640
(409) 724-7389

DOB	Age	Sex	HT	WT	RM-BD	PT	SVC	FC

Allergies:

Attending Physician Name: