Surgery Scheduling Form

Surgery Date: _____Surgery Time: _____
PAT Date: _____Time: _____

Patient (Legal) Name:_____ DOB: _____
SS# Last 4 Digits: _____ Gender *(M/F)* _____

Parent/Guardian (***if patient is a minor***):_____
Parent/Guardian Address:
_____
Date of Birth: _____ Gender:(*M/F)* _____

Insurance: _____

Preferred Phone Number: _____Phone Type: (Cell, Home, Work) _____
Alternate Phone Number: _____Phone Type: (Cell, Home, Work) _____
Name/Relation of Alternate Number: _____
Email: _____

Surgeon: _____ Clinic: _____

Surgeon Assisting:_____

Critical components
Procedure to be Performed:
_____
_____
_____
_____

Procedure Location:(*circle*) Right Left Bilateral

CPT Codes:
_____

Additional Procedure Details:
_____
_____

Special Requests (*i.e. Nuc. Med, Trays, Special Supplies, Implants, Sales Reps*):
_____
_____

Case Length: _____ Anesthesia *(circle)*: General MAC, Local, Regional, Epidural, Spinal

Patient Type *(circle Type)*: IP, SDA, OP, OPIB(OP In Bed)

Interpreter? (Y)__(N)__ Language Needed? _____

Surgery Scheduling Fax Number: 706-217-1028
Surgery Scheduling Phone Number: 706-272-6276
FIN_____