WESTON OUTPATIENT SURGICAL CENTER

SURGERY SCHEDULING REQUEST FORM

Attn: Yaira Schmidt Tel: 954-703-3051 Fax: 954-703-3151
Email: Yaira.Roche@westonasc.com

Today's Date_____

Patient Name_____ DOB:_____ Sex:____ SS # _____

Address_____

Home Ph #_____ Cell Ph # _____ Work Ph #_____ Ext._____

Primary Insurance / Payor

□ HMO (in-network only)- □ HMO/POS - □ PPO - □ Self Pay □ Medicare (regular) - □ Medicare HMO □ Medicaid

□ Worker's Comp - □ Auto □ Legal

Date of Accident or Illness: / / -- Front and Back Copy of Insurance Cards Submitted: □ Yes □ No

Insurance Carrier _____ Phone #_____

Insurance Address _____

Insured's Name _____ Patient Relationship to Insured: □ Self □ Spouse □ Child/Dependant

Insured's Employer _____ Insured Emp's Ph #_____

Insured's SS #_____ ID # _____ Group #_____ W/C or Auto Claim # _____

Pre-Certification #_____ Contact Name_____ Phone # _____

Secondary Insurance Carrier _____ Ph # _____ ID # _____ Grp # _____

Surgeon / Surgery Information

Surgeon Name _____ Contact _____ Ph #_____Fax #_____

Date of Surgery _____/_____/_____ **Time of Surgery**_____ **Length**_____ Type **of Anesthesia**_____

Primary Diagnosis _____ ICD 10 code_____

Secondary Diagnosis _____ ICD 10 code _____

Primary Procedure _____ CPT code_____

Secondary Procedure _____ CPT code _____

CONSENT TO READ (PLEASE COMPLETE FILL OUT):

_____

_____ □ Right □ Left □ Bilateral □ NA

Special Equipment / Other Needs_____

Pre-Existing Condition: □ DIABETES □CARDIAC □NEURO □CARCINOMA □ OTHER_____

Pre Op Labs to be done: □ CBC □ SMA □ UA □ SERUM PREG □ PT □ PTT □ OTHER_____

Pre-Op Labs being done at _____ Phone #_____

Medical Clearance by Dr. _____ Phone #_____

*****Please Fax Physician Orders and Front & Back Copy of Primary and Secondary Insurance Card(s)*****