Elmhurst Outpatient Surgery Center Surgery Scheduling Form

1200 S. York Road | Suite 1400 | Elmhurst, IL 60126
331.221.4633 (scheduling phone) | 331.221.3929 (scheduling fax)

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **DOB:** _____ **Gender:** ☐ M ☐ F

Name should appear as it is listed on the patient's Medicare ID card or for other payers, as it appears on the driver's license/state ID.

Is the patient a resident of a nursing home? ☐ Yes ☐ No **Name:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

CELL Ph: _____ **Home Ph:** _____ **Work Ph:** _____

1° Language: _____ **Email:** _____

Cell phone and email are needed to prompt patients to complete their online medical history on EOSC's website.

☐ Local patient may drive self home (surgeon must write order in EOSC chart on DOS)

INSURANCE INFORMATION

1° Insurance: _____ **Policyholder Name:** _____

ID #: _____ **Policyholder DOB:** _____

Group #: _____ **Insurance Phone #:** _____

2° Insurance: _____ **Policyholder Name:** _____

ID #: _____ **Policyholder DOB:** _____

Group #: _____ **Insurance Phone #:** _____

If Workers' Comp, complete this section:

Employer: _____ **Employer Phone:** _____

WC Carrier: _____ **Adjuster Name:** _____

Auth #: _____ **Adjuster Phone:** _____

PROCEDURE INFORMATION

DOS: _____ **Surgeon:** _____

Case Time: _____ **Case Length:** _____

Procedure(s): _____

_____

_____

_____

*The procedure listed above on the EOSC surgical consent. Do **NOT** use abbreviations. Include ALL **possible** procedures.*

Diagnosis: _____

Anesthesia Type		SA Needed	Other Special Requests/Information
☐ Local ☐ IVCS ☐ MAC ☐ General	☐ Choice ☐ Bier ☐ Regional/Axillary ☐ Spinal ☐ No Anesthesia	☐ Yes ☐ No	

Completed by: _____ **Date:** _____

EOSC will follow its Pre-Admission Assessment and Screening Policy for pre-admission testing. Physicians that require additional testing must order this directly and have results faxed to EOSC at 331.221.3926.