CHC Surgical Center

PATIENT SCHEDULING SHEET

Fill out and fax to scheduler with any Physician's "Pre-Surgical Orders" to:

Scheduling email: $(\underline{a.agnew@chcsurgical.com}\ and$

roser@chcsurgical.com)

Scheduling Phone Number: (718-422-7600)

				INFORI		1 1				
Date of Procedure:				neduled Time			ΑM	F	rocedure	Length:
	Mon Tues Wed	d Thurs Fri Sat				F	PM			
Patient's Name: (Last)	(First)	ı	(MI)				S	Surgeon:	
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Address:								Δ	ssistant:	
Addicoo.								'	ooiotant.	
City:			Sta	to: Zin:			45110			
City:			Sia	te: Zip:			ous AFHC pa			
		T				`	Yes No)		
Social Security Number:		Date of Birth:		Age:			Sex:			
Home Phone:	Cell Phone:		Ane	esthesia Typ	e:					
			0	General	MAC	Local	Block	Choice	e Co	nscious Sedation
Best number to contact	May we leave a mes	sage?	u .							
you:	Hamai Vaa	NI-	0-1	l. V	Na	Emergeno	y Contact:			
Home Cell	Home: Yes	No	Cel	I: Yes	No	Phone:				Relation:
Pre-op DX / ICD 9 Code:						Rigr	nt Left Bil	ateral		
Procedure(s)/CPT C	odos:									
	oues.									
Special Equipment Needs	:									
			JRANCI	E INFOR	RMATI	ON				
Responsible Party Name	and Address (if differen		JRANCI	E INFO	RMATI	ON				
	·	t than above):								
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Printed By: claudiawp Printed on: 10/18/2017

Patient Information

Personal Information				
First Name	EMILY	Middle Name	-	
Last Name	EDWARDS	D.O.B	01/24/2003	
Gender	Female	Address	423 SOUTH FULLTON AVE APT3	
City	MOUNT VERNON	State	NEW YORK	
Cell Phone #	347-206-6391	Home Phone	718-881-5845	
Work	-	Zip	10553	
Email	-	Extn.	-	
Attorney	DOMINICK LAVELLE	Case Type	No-Fault	
Attorney Address	100 HERRICKS ROAD SUITE 201	Attorney Phone	800-745-4878	
Case Status	OPEN	SSN	-	

Insurance Information					
Policy Holder	-	Name	LIBERTY MUTUAL INS.		
Address	P.O. Box# 1052	City	Montgomeryville		
State	PENNSYLVANIA	Zip	18936-1052		
Phone	800 245-1700	Fax	-		
Contact Person	-	Claim File #	034381648		
Policy #	AOS228001979405	WCB Group			

Accident Information				
Accident Date	09/14/2016	Plate Number	-	
Report Number	-	Address	-	
City	-	State	-	
Hospital Name	-	Hospital Address	-	
Date of Admission	-	Additional Patient	-	
Describe Injury	-	Patient Type	Passenger	

Employer Information				
Name	-	Address	-	
City	-	State	-	
Zip	-	Phone	-	
Date of First Treatment	-	Chart #	-	

Adjuster Information				
Name	-	Phone	-	
Extension	-	Fax	-	
Email	-			

Source : https://www.gogreenbills.com