ALLCITY FAMILY HEALTHCARE SURGERY CENTER

PATIENT SCHEDULING SHEET

Fill out and fax to scheduler with any Physician's "Pre-Surgical Orders" to:
Scheduling Fax: (718) 332-4472
Scheduling Phone Number:(718) 332-4409

PATIENT INFORMATION

Date of Procedure:	Mon Tues Wed Thurs Fri Sat	Scheduled Time: AM PM	Procedure Length:
Patient's Name: (Last) (First) (MI)			Surgeon:
Address:			Assistant:
City:	State:	Zip:	Previous AFHC patient? ☐ Yes ☐ No
Social Security Number:	Date of Birth:	Age: Sex:	
Home Phone:	Cell Phone:	Anesthesia Type: General ☐ MAC ☐ Local ☐ Block ☐ Choice ☐ Conscious Sedation	
Best number to contact you: Home Cell	May we leave a message? Home: ☐ Yes ☐ No	Cell: ☐ Yes ☐ No	Emergency Contact: Phone: Relation:

Pre-op DX / **ICD 10 Code(s)**: Right Left Bilateral

Procedure(s)/**CPT Code(s)**:

Special Equipment Needs:

INSURANCE INFORMATION

Responsible Party Name and Address (if different than above):

Relation to Responsible Party: Self Child Spouse Other	Subscriber's Birth Date	Responsible Party Employer:	Responsible Party Phone:

Primary Insurance Carrier / Name of Insured	**Secondary** Insurance Carrier / Name of Insured:
Insurance Billing Address and Phone	Secondary Billing Address and Phone:

ID / SS#:	Group #:	Authorization #:	ID / SS#:	Group #:	Authorization #:
Insured's Employer and Phone #:			Insured's Employer and Phone #:		

NF/Worker's Comp Info:	D.O.I.:	Claim #:	Adjustor:

PRE-ADMISSION PHYSICIAN ORDERS

For Local or MAC o Start IV of Normal Saline o No IV

Date:	Time:	Signature:

REVISED 11/15

Patient Information

Personal Information

First Name		**Middle Name**	
Last Name		**D.O.B**	
Gender		**Address**	
City		**State**	
Cell Phone #		**Home Phone**	
Work		**Zip**	
Email		**Extn.**	
Attorney		**Case Type**	
Attorney Address		**Attorney Phone**	
Case Status		**SSN**	

Insurance Information

Policy Holder		**Name**	
Address		**City**	
State		**Zip**	
Phone		**Fax**	
Contact Person		**Claim File #**	
Policy #		**WCB Group**	

Accident Information

Accident Date		**Plate Number**	
Report Number		**Address**	
City		**State**	
Hospital Name		**Hospital Address**	
Date of Admission		**Additional Patient**	
Describe Injury		**Patient Type**	

Employer Information

Name		**Address**	
City		**State**	
Zip		**Phone**	
Date of First Treatment		**Chart #**	

Adjuster Information

Name		**Phone**	
Extension		**Fax**	
Email			