CHC Surgical Center

PATIENT SCHEDULING SHEET

Fill out and fax to scheduler with any Physician's "Pre-Surgical Orders" to:
Scheduling email: (a.agnew@chcsurgical.com and
roser@chcsurgical.com)
Scheduling Phone Number :(718-422-7600)

PATIENT INFORMATION

Date of Procedure: txt_date1|ToDay	Mon Tues Wed Thurs Fri Sat	Scheduled Time: AM PM	Procedure Length:
Patient's Name: (Last) txt_lname|LastName	(First) txt_fname|FirstName	(MI) txt_mname|MiddleName	Surgeon:
Address: txt_address|Address1			Assistant:
City: txt_city|City	State: txt_sta	Zip: txt_zip|Zip	Previous AFHC patient? Yes No
Social Security Number: txt_ssn|SSN	Date of Birth: txt_dob|DOB	Age: txt_age|AGE	Sex: txt_sex|Sex
Home Phone: txt_Phone2|Phone	Cell Phone: txt_mob|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 9 Code:		Right Left Bilateral	
Procedure(s)/**CPT Codes**:			
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 txt_InsCo|InsCo		**Secondary** Insurance Carrier / Name of Insured:			
Insurance Billing Address and Phone txt_Insaddress|InsAddress1		Secondary Billing Address and Phone:			
ID / SS#:	Group #:	Authorization #:	ID / SS#:	Group #:	Authorization #:
Insured's Employer and Phone #:			Insured's Employer and Phone #:		
Worker's Comp Info:	D.O.I.: txt_doa|	Claim #: txt_ClaimNumb	Policy # txt_policy_no|policy_no	Adjustor: txtAdjuster|AdjUserName	
For All Workman's Compensations and No Fault cases Please submit along with Case Booking form.		**1. H&P 2. Initial Evaluation 3. MRI report 4. Letter of Medical Necessity**		**Attorney Info.**	

PRE-ADMISSION PHYSICIAN ORDERS

Testing: o H & H o FBS if diabetic o Urine Preg o EKG		
For Local or Conscious Sedation o Start IV of Normal Saline o No IV		
Date: txt_date|ToDay	Time:	Signature:

Patient Information

Personal Information

First Name	txt_fname|FirstName	**Middle Name**	txt_mname|MiddleName
Last Name	txt_lname|LastName	**D.O.B**	txt_dob|DOB
Gender	txt_sex|Sex	**Address**	txt_address|Address1
City	txt_city|City	**State**	txt_state|State
Cell Phone #	txt_mob|Phone	**Home Phone**	txt_Phone2|Phone
Work	txt_work_phone|work_phone	**Zip**	txt_zip|Zip
Email	txt_eMail|EmailAddress	**Extn.**	
Attorney	txt_attorney|Attorney	**Case Type**	txt_casetype|WCBGroup
Attorney Address	txt_attorneyAdd|AttorneyAdd	**Attorney Phone**	txt_attorneyPhno|AttorneyPhno
Case Status		**SSN**	txt_ssn|SSN

Insurance Information

Policy Holder	txt_name123|patientfullname	**Name**	txt_InsCo|InsCo
Address	txt_Insaddress987|InsAddress1	**City**	txt_Inscity|InsCity
State	txt_Insstate987|InsState	**Zip**	txt_Inszip|Inszip
Phone	txt_InsPhone987|InsPhone	**Fax**	
Contact Person		**Claim File #**	txt_ClaimNumber|ClaimNumbe
Policy #	txt_policy_no|policy_no	**WCB Group**	txt_WCBGroup|WCBGroup

Accident Information

Accident Date	txt_doa|DOA	**Plate Number**	
Report Number		**Address**	
City		**State**	
Hospital Name		**Hospital Address**	
Date of Admission	txt_doe12|LASTDOE	**Additional Patient**	
Describe Injury		**Patient Type**	

Employer Information

Name	txt_EmpName|EmpName	**Address**	txt_EmpAddress|EmpAddress
City		**State**	
Zip		**Phone**	txt_EmpPhone|EmpAddress
Date of First Treatment		**Chart #**	

Adjuster Information

Name	txtAdjuster|AdjUserName	**Phone**	txtAdjusterph|AdjPhone
Extension		**Fax**	
Email			