

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:	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 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			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 #:		
Worker's Comp Info:		D.O.I.:	Claim #:	Policy #	Adjustor:
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:	<input type="radio"/> H & H	<input type="radio"/> FBS if diabetic	<input type="radio"/> Urine Preg	<input type="radio"/> EKG
For Local or Conscious Sedation	<input type="radio"/> Start IV of Normal Saline	<input type="radio"/> No IV		
Date:	Time:	Signature:		

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	-		