



# Surgical Services Booking Office

**PATIENT DATA:**

Name: \_\_\_\_\_ Gender: M \_\_\_ F \_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_ Social Security: \_\_\_\_\_  
 Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**SURGICAL INFORMATION:**

Surgery Date: \_\_\_\_\_ Estimated Time of Procedure: \_\_\_\_\_ Case No.: \_\_\_\_\_  
 Surgeon: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Send Confirmation Email to: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ ICD# \_\_\_\_\_  
 Procedure: \_\_\_\_\_ Side: RT: \_\_\_ LEFT: \_\_\_ BILATERAL: \_\_\_ N/A: \_\_\_  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_

**EQUIPMENT:**

Radiology: \_\_\_\_\_ Table: \_\_\_\_\_ Other: \_\_\_\_\_  
 Implants: \_\_\_\_\_ Miscellaneous: \_\_\_\_\_

**ANESTHESIA:**

Type: \_\_\_\_\_ Position: \_\_\_\_\_ Other: \_\_\_\_\_  
 Cell-Saver: Yes \_\_\_ No \_\_\_ Miscellaneous: \_\_\_\_\_

**SPECIAL PRECAUTIONS:**

Latex Allergy: Yes \_\_\_ No \_\_\_ Other: \_\_\_\_\_

**ADMISSION DATA:**

Type of Admission: \_\_\_\_\_ Site of Admission: \_\_\_\_\_  
 PCP: \_\_\_\_\_  
 Admission Date: \_\_\_\_\_ Admission Time: \_\_\_\_\_ Bed Request: \_\_\_\_\_ Length of Stay: \_\_\_\_\_  
 Presurgical Evaluation: Yes \_\_\_ No \_\_\_ Date: \_\_\_\_\_ POP Tour: Yes \_\_\_ No \_\_\_ Date: \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
 Primary Insurance Subscriber: \_\_\_\_\_ Policy # \_\_\_\_\_ Phone: \_\_\_\_\_  
 Secondary Insurance Subscriber: \_\_\_\_\_ Policy # \_\_\_\_\_ Phone: \_\_\_\_\_  
 Workers' Compensation:  
 Employer: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of injury: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_