Scheduling Form
Phone: 856-582-2072 Fax: 856-218-2071
Please fax a front and back of the insurance card with this form

Booking Date:______________________________
By Whom: ______________________________

Date of Surgery: ____________ Time Requesting: ______________________________

Duration of Surgery: ______________ Surgeon:______________________________

Patient's Name:______________________________

Address:______________________________

City ______________ State ____________ Zip ______________

SS #______________ DOB____________ Sex ______________

Patient PREFERRED contact source for preoperative info & surgical time Email:______________

Primary Contact Phone # ______________ **Secondary Contact Phone #** ______________

Employer ______________________________

City ______________ State ____________ Zip ____________

Anesthesia Type: Gen _____ Block _____ MAC _____ Other____________ (*)BMI ________

CPT Code: ______________ Procedure: ______________________________
CPT Code: ______________ Procedure: ______________________________
CPT Code: ______________ Procedure: ______________________________

ICD 10 Code: ____________Diagnosis: ______________________________

ICD 10 Code: ____________ Diagnosis:______________________________

Special Instructions/ Equipment:______________________________

Does patient need interpreter? __________ **If yes, what language?** ______________________

Pre-Admission Testing:
_____Not required Required tests: ______________ Diabetic Y N
_____Results will be faxed Latex Allergy Y N
_____Results to be sent with Patient

Insured Name ______________________ Relation to Patient ____________
Primary Insurance ______________________ Phone ______________
ID #______________ Group ______________ Plan Type____________

Secondary Insurance______________________ Phone______________
Insured Name______________________ Relation to Patient____________
ID #______________ Group ______________ Plan Type____________
If patient is w/c: Date of injury______________ Claim # ______________
Adjustor Name______________________ Phone______________

Please fax this request to (856) 218-2071

I have received a Select Surgical Center Patient Brochure **Y N**
I have been informed that Dr. ______________ **Does Does Not** have financial ownership in the Center.

Patient Signature______________________________ **Date**______________