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 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 #:	Adjustor:

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:	Time:	Signature: