SURGICAL AND PAIN CENTER OF SCOTTSDALE SCHEDULING AND DEMOGRAPHICS FORM

PATIENT DEMOGRAPHICS

PATIENT LAST NAME	FIRST NAME	Middle Initial	DOB	SSN	SEX

ADDRESS	CITY, STATE, ZIP

HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS

SURGEON:	SURGICAL ASSISTANT:

SURGERY DATE	SURGERY TIME	LENGTH OF SURGERY

DIAGNOSIS

PROCEDURE

CPT CODES	ICD-10 CODES

ANESTHESIA PLAN: ☐ GENERAL ☐ MAC ☐ LOCAL ☐ BLOCK ☐ RN SEDATION ☐ IV SEDATION

ANESTHESIA GROUP/PHYSICIAN

SPECIAL SUPPLIES: ☐ SCREWS/PLATES ☐ IMPLANTS ☐ BIG C ARM ☐ MINI C ARM ☐ OTHER:

COMPLETED BY:	DATE:

INSURANCE DEMOGRAPHICS

MARITAL STATUS: M S D O	RELATIONSHIP TO INSURED:	INSURED SS#:

INSURED NAME:	INSURED DOB:	INSURED EMLOYER:

INSURANCE COMPANY:	PHONE:

ID#:	GRP#

AUTH:	CONTACT :	PHONE:

SECONDARY INSURANCE	PHONE:

ID#:	GRP#:

AUTH:	CONTACT :	PHONE:

IF CASE IS INDUSTRIAL, DATE OF INJURY	CLAIM NUMBER:

YOU MUST FAX A LEGIBLE INSURANCE CARD COPY WITH THIS FORM

PHYSICIAN ORDERS

ADMITTING RN CONFIRM PROCEDURE LISTED ABOVE	☐ PT IS AN APPROPRIATE CANDIDATE FOR AMBULATORY SURGERY

ALLERGIES:

PREOP MEDICATIONS: ☐ NONE ☐ ANCEF 1 GM IV PUSH PRIOR TO PROCEDURE ☐ ANCEF 2 GM IV PUSH PRIOR TO PROCEDURE ☐ OTHER:

SPECIAL REQUESTS:

SURGEON SIGNATURE	DATE

NOTED BY RN	TIME	DATE