EMU Surgical Center

Surgical Scheduling Form

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Patient Demographics					
Last Name	First Name	MI	Gender	Date of Birth	Age
Address					
SS#	Main Phone		Secondary Phone		
Special Needs? Please list.	Allergies? (Y / N) Please list.		Interpretation Services Needed?		

Surgery Information				
Date	Requested time	Surgery Length (mins)	R /L /Bil	Admitting Physician
Anesthesia Type: Gen / MAC / Local	**BMI or H/W**	Special Equipment/Implants		
Procedure #1		CPT	ICD	
Procedure #2		CPT	ICD	
Procedure #3		CPT	ICD	
PAT: EMU / PCP / Surgeon		Date/Time		

Insurance Information (Please attach copy of front/back of insurance card)		
Primary Insurance	Policy #	Policy Holder's Name
Secondary Insurance	Policy #	Relation to Patient
Auth #	Auth Comments	
PCP Name		Phone
Date of Accident	Attorney	Phone

Scheduler	Phone