



The information contained in this form is needed. To schedule a surgery, please utilize this form, fax it to the surgery scheduling desk (**fax: 805-418-1387**), and phone the scheduling office (**805-418-1300**) to arrange for the surgery date and time.

Surgeon:		Assistant:	
Admitting M.D. If not Surgeon:	Date of Surgery:	Time: <input type="checkbox"/> AM / <input type="checkbox"/> PM	<input type="checkbox"/> IP No. of Days: _____ <input type="checkbox"/> OP <input type="checkbox"/> Observation Status
Patient Last Name:	Patient First Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
Home Phone #: ()	Work Phone#: ()	SSN:	
Home address:			
Procedure:			
Where will Pre-Op Lab. & X-Rays be completed:			
Estimated Length:	Anesthesia: <input type="checkbox"/> Gen <input type="checkbox"/> MAC <input type="checkbox"/> Local <input type="checkbox"/> Block <input type="checkbox"/> None	C-Arm / X-Ray: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Special Equipment:			
DX:		Special Needs – Interpreter, Diet, other:	
CPT Code:		ICDM9#:	
*Insurance:		ID#:	Group #:
Subscriber Name:		Subscriber DOB:	Subscriber SSN:
Authorization:	Cert #:	Telephone: ()	Spoke with:
W/C Insurance:		Adjuster:	Telephone: ()
Claim #:		DOI:	Authorized by:
Secondary Insurance:		ID#:	Group #:
Surgery Scheduled With:			
Date:		Telephone: ()	

***Please provide a copy of the front and back of the insurance card.**