STERLING SURGICAL HOSPITAL

PATIENT SCHEDULER

985.690.8250 (p) ❖ 985.690.8259 (f)
989 Robert Blvd., Slidell, LA

PROCEDURE DATE:_____

MD:_____ ☐ IN PATIENT ☐ OUT PATIENT

PATIENT INFORMATION Please Print

NAME:_____DOB: _____ AGE: _____
LAST FIRST MI

SSN: _____ SEX: ☐ Male ☐ Female PHONE: _____/_____
HOME CELL

ADDRESS: _____ DIABETIC: ☐ Yes ☐ No SMOKER: ☐ Yes ☐ No

CITY:_____ STATE:_____ ZIP:_____ RACE:_____ LANG:_____ RELIGION:_____

EMERGENCY CONTACT: _____ PHONE: _____ RELATION: _____

SURGERY INFORMATION Please Print

DIAGNOSIS CODE(S):_____ _____ _____

PROCEDURE: _____

ANESTHESIA: ☐ MAC ☐ GENERAL ☐ BIER BLOCK (AUX) ☐ LOCAL ☐ NONE

CPT DESCRIPTION: _____ _____
_____ _____
_____ _____

AREA: ☐ RIGHT ☐ LEFT ☐ UPPER ☐ LOWER ☐ BILATERAL ☐ OTHER_____

INSURANCE INFORMATION Please Print

COMPANY:_____ I.D. NO.: _____GROUP NO.:_____

POLICY HOLDER: _____ RELATION: _____ SELF AUTH NO._____

D.O.B._____

SECONDARY INSURER (if necessary)

COMPANY:_____ I.D. NO.: _____GROUP NO.:_____

POLICY HOLDER: _____ RELATION: _____ SELF AUTH NO._____

D.O.B._____

MEDICARE NO.: _____EFFECTIVE DATE:_____

MEDICAID NO.:_____EFFECTIVE DATE:_____

ADDITIONAL NOTES:

_____

_____

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PLEASE FAX FORM AND ANY CLEARANCES TO 985.690.8259 OR EMAIL TO: scheduler@sterlingsurgical.net

PLEASE INCLUDE: Photocopy of Identification and Insurance Cards AND Physician Orders