

**SILICON VALLEY SURGERY CENTER, L.P.**, 14601 S Bascom Ave, Ste 100, Los Gatos, CA 95032 ▪ 408/402-0663 ▪ FAX 408/402-7055 ▪  
 **BASCOM SURGERY CENTER, L.P.**, 3803 S Bascom Ave, Ste 106, Campbell, CA 95008 ▪ 408/369-9535 ▪ FAX 408/402-7055  
**DIRECT SCHEDULING PHONE 650/289-1653 (Rosie Herauf) ▪ DIRECT FAX 408/402-7070**

**SURGERY SCHEDULING FORM**

**EMAIL:**

<b>Date:</b>	_____
<b>Time:</b>	_____
<b>AnesType:</b>	_____
<b>OR Time:</b>	_____
<b>Surgeon</b>	_____
<b>Assistant</b>	_____
<input type="checkbox"/> Diabetic	<input type="checkbox"/> Weight > 300 lbs. _____
<b>PRE-OP TESTS</b>	<input type="checkbox"/> None <input type="checkbox"/> EKG
<input type="checkbox"/> Labs	_____

<b>Patient</b>	_____				<b>Male</b>	<b>Female</b>
	Last. First. Middle Initial					
<b>Date of Birth</b>	_____	<b>S.S.#</b>	_____	<b>Martial Status</b>	<b>M</b>	<b>S</b>
					<b>D</b>	<b>W</b>
<b>Address</b>	_____			<b>Home Phone:</b>	_____	
<b>City/State/Zip</b>	_____			<b>Work Phone:</b>	_____	
<b>Employer</b>	_____			<b>Cell Phone:</b>	_____	
<b>Procedure</b>	<b>CPT:</b> _____					
	<b>CPT:</b> _____					
	<b>CPT:</b> _____					
	<b>CPT:</b> _____					

<b>Diagnosis</b>	<b>ICD-9:</b>	_____
	<b>ICD-9:</b>	_____
	<b>ICD-9:</b>	_____
	<b>ICD-9:</b>	_____

<b>INSURANCE COMPANY - PRIMARY</b>	
<b>I.D. #</b>	<b>Grp #:</b>
_____	_____
<b>Phone:</b> _____	

<b><u>Insurance Information – Primary</u></b> (If other than patient)	
<b>SUBSCRIBER</b>	Relationship
_____	_____
<b>Address</b> _____	
<b>Phone</b> (If different)	<b>DOB:</b>
_____	_____
<b>SUBSCRIBER Employer</b>	<b>Work Phone</b>
_____	_____
<b>Address</b> _____	

<b>INSURANCE COMPANY - SECONDARY</b>	
<b>I.D.#</b>	<b>Grp #:</b>
_____	_____
<b>Phone:</b> _____	

<b>SPECIAL EQUIPMENT/ INSTRUMENT/ IMPLANT REQUEST</b>

<b>WORKERS' COMP INFO.</b>	<b>Adjuster:</b>
<b>DOI:</b>	<b>CLM#:</b>
_____	_____
<b>Auth'd By:</b>	_____
<b>Date of Auth:</b>	<b>FAX#:</b>
_____	_____

<b>Position:</b> <input type="checkbox"/> Prone <input type="checkbox"/> Supine <input type="checkbox"/> Beach Chair <input type="checkbox"/> Lateral <input type="checkbox"/> Other: _____	<b>Financial Disclosure:</b> _____	<b>Date:</b> _____
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