

**REAGAN STREET SURGERY CENTER**

**SCHEDULING FAX FORM**

Phone # 562-596-3140

Fax# 562-596-3142

Surgeon \_\_\_\_\_ Surgery Date: \_\_\_\_\_ Surgery Time: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SEX: M F

Patient's Address: \_\_\_\_\_

Subscribers Name if different than patient: \_\_\_\_\_ DOB: \_\_\_\_\_

SS#: \_\_\_\_\_ Phone # \_\_\_\_\_ cell/wk/other

Insurance Information \_\_\_\_\_ (please send copy of Ins card/demographics)

Subscribers Name if different than patient: \_\_\_\_\_ DOB: \_\_\_\_\_

SS# \_\_\_\_\_ Relationship to patient:  Parent  Spouse  Other

(If insurance carrier is Workers Comp, please send Adjusters name, phone # and date of injury)

ID# \_\_\_\_\_ Group# \_\_\_\_\_ Ins phone # \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

LATEX ALLERGY -YES OR NO

LATEX SENSITIVITY- YES OR NO

ANESTHESIA TYPE: LOCAL / MAC / GENERAL / IV SEDATION / CONSCIOUS SEDATION

EPIDURAL / SPINAL / NONE / OTHER \_\_\_\_\_

**Procedure/s**

(When scheduling lesion removal include the lesion size)

\_\_\_\_\_  
\_\_\_\_\_

Diagnosis: \_\_\_\_\_

CPT Code: \_\_\_\_\_ ICD9: \_\_\_\_\_

Length of procedure \_\_\_\_\_ SPECIAL EQUIPMENT NEEDED YES / NO

Equipment/supplies needed please describe \_\_\_\_\_

Referring Physician and Fax #: \_\_\_\_\_

Completed and faxed by \_\_\_\_\_ Phone# \_\_\_\_\_