

**WAVERLEY SURGERY CENTER
SURGERY SCHEDULING FORM**

Date: _____
Time: _____
AnesType: _____
OR Time: _____
Surgeon: _____
Assistant: _____
23 HOUR STAY
<input type="checkbox"/> Diabetic <input type="checkbox"/> Weight > 300 lbs. _____

Patient _____ Last. First. Middle Initial	Primary Language _____	Male _____	Female _____
Date of Birth _____	S.S.# _____	Marital Status M S D W	
Address _____	Home Phone: _____		
City/State/Zip _____	Work Phone: _____		
Employer _____	Cell Phone: _____		
Procedure CPT: _____	_____		
Description CPT: _____	_____		
_____	_____		
_____	_____		

Diagnosis ICD-9: _____
Description ICD-9: _____

INSURANCE COMPANY - PRIMARY	
_____	_____
_____	_____
I.D. #: _____	Grp #: _____
Phone: _____	

Insurance Information – Primary (If other than patient)	
SUBSCRIBER _____	Relationship: _____
Address _____	
Phone (If different _____)	DOB: _____ S.S.#: _____
SUBSCRIBER Employer _____	Work Phone: _____
Address _____	

INSURANCE COMPANY - SECONDARY	
_____	_____
_____	_____
I.D.#: _____	Grp #: _____
Phone: _____	

SPECIAL EQUIPMENT/ INSTRUMENT/ IMPLANT REQUEST

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

WORKERS' COMP INFO.	Adjuster: _____
DOI: _____	CLM#: _____
Auth'd By: _____	
Date of Auth: _____	FAX#: _____
Financial Disclosure: _____	