American Surgery Center

YOUR AMBULATORY SURGERY CENTER IN WILMINGTON, DE

CASE #: _____

BOOKING DATE: _____

BY WHOM: _____

Please fax completed form to 302.777.2111

PLEASE SEND BOOKING SHEETS AT LEAST ONE WEEK BEFORE THE PROCEDURE DATE!

LAST NAME _____ FIRST NAME_____

D.O.B. _____/_____/_____ AGE _____ SEX _____ EMAIL _____

ADDRESS _____

HOME PHONE (_____)_____ WORK PHONE (_____)_____ CELL #(_____)_____

IF MINOR, A PARENT OR GUARDIAN MUST ACCOMPANY PATIENT THE DAY OF SURGERY.

PRIMARY PHYSICIAN _____ PHONE # (_____)_____

SPECIALIST NAME AND PHONE #i.e. Cardiologist/Pulmonary/Renal _____

EMPLOYER _____ FAMILY CONTACT _____

PRIMARY INSURANCE _____ POLICY # _____

SECONDARY INSURANCE _____ POLICY # _____

SOCIAL SECURITY # _____

POLICY HOLDER: SELF _____ SPOUSE (DOB) _____ PARENT _____ OTHER_____

PRECERT REQUIRED _____ CERT. # _____

MAIL CLAIM TO: _____

_____

LATEX ALLERGY? ☐ YES ☐ NO **IF YES**, TYPE OF REACTION: _____

DOES THIS PATIENT HAVE AN AICD (AUTOMATIC IMPLANTED CARDIAC DEFIBRILLATOR)?

☐ YES ☐ NO **IF YES, CARDIAC CLEARANCE IS REQUIRED**

DATE OF INJURY _____ (MVA/WC) adjuster name/phone/address _____

_____

SURGEON_____ DATE OF SURGERY _____

ASSISTANT_____ TIME OF ARRIVAL _____

LENGTH OF SURGERY_____ TIME OF PROCEDURE _____

DIAGNOSIS_____

PROCEDURE_____

_____

DX: CODE (S) _____**CPT CODE(S)**_____

ANESTHESIA TYPE: GEN _____ BLOCK _____ MAC_____ OTHER _____

EQUIPMENT OR DEVICES NEEDED: _____

_____

COMMENTS _____

DO YOU NEED TRANSPORTATION? ☐ YES ☐ NO **ARE YOU DIABETIC?** ☐ YES ☐ NO

I HAVE RECEIVED A COPY OF THE AMERICAN SURGERY CENTER PATIENT BROCHURE. ☐ YES ☐ NO

I HAVE BEEN INFORMED THAT DR. _____ DOES NOT HAVE FINANCIAL OWNERSHIP IN THE CENTER.

PATIENT/PARENT/GUARDIAN SIGNATURE _____ DATE: _____

RELATION TO PATIENT: SELF _____ SPOUSE_____ PARENT/GUARDIAN_____ OTHER_____