GREATER BATON ROUGE SURGICAL HOSPITAL
SCHEDULING FORM

Latex Allergy: Yes or No **Please check : ___Inpatient ___Outpatient ___23 HR/OBS**

Patient____ **SSN#**_______________________
Last **First** **M.**
Home Phone ______________________**Work**_______________________ **Age**__________

Address____

PCP Referring ____

Martial Status: **M S D W** **Date of Birth** ________________ **Gender: Male**______ **Female**________

Day/Date of Surgery______________**Start Time**____________ **1ST Choice** _______ **2nd Choice** _______

Anesthesia/Type: **Local General MAC** **Length of Surgery** ___________**Surgeon**____________________

Length of stay (specify # of days): ___ 1 day ___ 2 days ___ 3 days ___ 4 days ___ 5 days ___ 6 days ___ 7 days

Anatomical Site: ________________Please circle laterality of procedure site: LT RT Bilateral

<u>Pre-Op Diagnosis:</u> ________________________________ **Code:** ______________

________________________________ **Code:** ______________

<u>Procedure:</u> ________________________________ **Code:** ______________

________________________________**Code:** ______________

Special Equipment: C-arm, Fracture table, Laser, ABC, SCD'S, HIT, etc.______________________________

____

IMPLANT TYPE/SIZE ____

HMO_____ **PPO**_____**POS/EPO**____**W/C**_____ **SELF-PAY**______ **INDEM/COM**_______ **MCR** ______**MEDICAID**________

1. **PRIMARY INSURANCE** _______________ **INSURED** _____________ **PHONE#** _______________

   SSN# ____________________ **GROUP#** _________________ **ID#** _____________________

2. **SECONDARY INSURANCE**_____________ **INSURED** _____________ **PHONE#** _______________

   SS/ID# ____________________**GROUP#** ____________________ **ID#**_________________

PATIENT'S EMPLOYER ___________________________ **INSURED EMPLOYER** ____________________

ADDRESS ___________________________________ **ADDRESS**________________________________

___________________________________ ________________________________

Claim # ________________________________
Date of Injury ____________________________

Pre-Cert #: _________________ **Phone#** _________________**Contact:** ___________________________

Fax: ______________________________/ ______________________________/____________________
Doctor's Name **Called/Faxed By** **Received/Scheduled By**

PLEASE FAX A COPY OF OUR DEMOGRAPHIC SHEET <u>AND</u> INSURANCE INFORMATION TO: FAX 225-358-4939

REVISED 05/2010