St. Charles Surgery Center

Scheduling Booking Sheet

□ **1st visit** □ **2nd visit** □ **3rd visit** □ **Rescheduled Patient**

Today's Date:________________ Surgeon:_____________________ Scheduler:_____________________

Patient Name (First, Middle, Last):____

DOB:___________________ SSN(Required):________________________ Sex: □ Male □ Female

Home: (____)________________ Work: (____)________________ Cell: (____)________________

Address:_________________________________ City:_________________ State:_________ Zip:____________

Procedure Date:	Procedure Time:	Arrival Time:	Duration:

CPT:________________ Description:____

________________ ____

________________ ____

ICD-9:________________ ________________ ________________ ________________

Anesthesia Type (Circle One): Straight Local MAC with Retrobulbar MAC General

LENSX □ YES □ NO Lenstar Measurements: □ YES □ NO Restor Lens: □ YES □ NO Toric Lens: □ YES □ NO

Implant Needed/Information:______________________________ Specify IOL:_______________________

Equipment Needed:____

Patient has ICD or Defibrillator? □ YES □ NO
(answer required) If "YES" EP Clearance is required. Use "ICD Patient Clearance Form"

Is power of attorney required for this patient? (answer required) □ YES □ NO
If "YES" Name of POA:_________________________________ PH#:________________________________

Is a translator required for this patient?(answer required) □ YES □ NO If "YES" Language:__________________

<u>Primary Insurance Information:</u>
Plan:____ Group No:_______________________________________
Insured ID No:______________________________
Pre-Cert/Referral/Notification No (if applicable):_________________________

<u>Secondary Insurance Information:</u>
Plan:____ Group No:_______________________________________
Insured ID No:______________________________
Pre-Cert/Referral/Notification No (if applicable):_________________________

□ Signed HIPPA Release on file □ Patient has been provided with information regarding physician ownership, patient rights & responsibilities, and advanced directives

Please attach enlarged photocopies of insurance cards. Thank You. FAX: 636-757-1963