PATIENT PREADMISSION FORM

SURGERY Center OF LANCASTER

810 Plaza Blvd, Suite 101
Lancaster, PA 17601
Phone: 717-431-2368
Fax: 717-431-2540

TO BE COMPLETED BY SURGEON'S OFFICE (*Please Print Legible*) HERE BEFORE? Yes No When _____

SURGEON_____ ICD-9 Code(s) _____ CPT Codes(s)_____

Date/Time of Surgery _____ Length _____(min) Type of Anesthesia_____

Procedure Description:_____

Special Equipment: _____

Side: Right Left Bilateral *(Please circle if applicable, i.e. eye, limb, etc)* PCP NAME_____

COPIES OF INSURANCE ID CARDS (FRONT & BACK) ARE REQUIRED TO REGISTER THE PATIENT. Please fax copies with this form. Please inform the patient that they must present their insurance ID card the surgery center on the day of surgery.

PATIENT INFORMATION

Patient Name:_____ Date of Birth _____/_____/_____
LAST FIRST MI

Social Security #: _____

Address:_____ Sex ☐ Male ☐ Female

City _____State: _____ Zip: _____ Home Phone: _____

Martial Status : ☐ Single ☐ Married ☐Widowed ☐ Divorced

Responsible Party (if Patient is a Minor): _____ Relationship to Patient:_____

Responsible Party Social Security #: _____ Phone #: _____

Responsible Party Address (if different than Patient) _____ Alternate Phone #: _____

City _____State: _____ Zip: _____

Person(s) to Notify in Case of Emergency; _____ Relationship to Patient _____

Home Phone #: _____ Work Phone # : _____ Alternate Phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID/Policy #:_____

Insured's Name:_____ Group # _____

Auth/Ref#_____(Must be obtained before surgery can be scheduled)

Secondary Insurance: _____ ID/Policy #:_____

Insured's Name:_____ Group # _____

WORKER'S COMP INFORMATION

Worker's Comp: _____

Contact Name: _____

Phone: _____

Claim #: _____

EMPLOYER INFORMATION

Employer: _____

Employer Contact: _____

Employer Phone: _____

Date of Injury: _____