

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

Fax: 717-431-2540

TO BE COMPLETED BY SURGEON'S OFFICE (Please P.	<u>rint Legible)</u>	HERE BEFORE? Yes	No When
SURGEON	ICD-9 Code(s)		CPT Codes(s)
	ICD-10 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.			
	ie surgery center or	i the day of surgery.	
PATIENT INFORMATION			
Patient Name:		MI	
			Social Security #:
Address:			
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 #: Wo	rk 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		EMPLOYER INFORMAT	ION
Worker's Comp:		Employer:	
Contact Name:		Employer Contact:	
Phone:		Employer Phone:	
Claim #:		Date of Injury:	