BNHC Fort Jesse Surgery Center Scheduling Information

Scheduling Phone: 834-4002 **Fax**: 834-4008

Patient Information:

Last Name: __________________________ First Name:__________________ M.I.: ___

Date of Birth: ____/____/_____ Gender: **M** / **F** SSN: _________________________

Home Phone #: _____________________ Work Phone #: _________________ ext. ____

Surgery Information:

Date: ____/____/____ Time: _________ Duration and/or Case #: ___________________

Primary Insurance: _______________ Policy #_____________ Group #_______________

Insurance Pre-Certification Phone #_____________________ Anesthesia Type: ______

Diagnosis: ____

____

Comments: ____

Procedure(s): ____

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____

Physician: ________________________________

More Patient Information:

1. Drivers License #: _____________________________

Any other significant personal info such as: maiden name, race, religion, language, ect…

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____

2. Employment: Occupation (job title) ____

FT / PT / other: ________________________ Student Status: FT / PT / Non-student

Employer Address/ Phone #: ____

____

3. Patient Address: (home and/ or mailing)

____

____

4. **Related Party Insurance**: Self Responsible? **Yes** / **No** If No, fill out below:

Name: __________________________________ D.O.B.: ____/____/____ Gender: **M** / **F**

Address: ____

Phone #: ________________________________ SSN: ____________________________

Relationship to Patient: ____

Employment date effective: ____/____/_________

Occupation: _______________________________ Work Phone #: ___________________

Address: ____

Payer Name: ____

Faxed/ Sent by: ___________________________________

Date: _____/_____/_________ Time: _____________