Our Fax # 602-406-4179 Scheduling Line # 602-406-3533

ST. JOSEPH'S SURGERY CENTER & RECOVERY CARE CENTER

SCHEDULING FORM

Surgery Date:	Surgery Time:	Surgeon's Name:	
Patient's Email Address:			
Patient's Name:		Social Security #:	
Home or Mailing Address:			Zip Code:
Date of Birth:		Gender: *Female* *Male*	
Home Phone #:		Alternate/Cell Phone #:	
Patient's Weight:		Patient's Height:	
Known SLEEP APNEA	***NO*** ***YES***		
Primary Care Insurance:			Insurance Phone #:
Primary Care Insc ID #:			Primary Care Insc Group #:
Secondary Care Insurance:			Insurance Phone #:
Secondary Care Insc ID #:			Secondary Care Insc Group #:
* * * ***PLEASE FAX A COPY OF THE INSURANCE CARD*** * * *			
Private Pay Quote:		Given By: *Norma* *Heather*	
Surgical Procedure / CPT Codes(s):			
Length of Surgery:		*(Please include 15 minute turnover)*	
Diagnosis / ICD9 Codes(s):			
Check Anesthesia type:	*Local* *General*	*Stand-by (Mac)*	*Other*
Check one:	*Scheduling to get anesthesia*	*Office will get anesthesia*	
Implants needed/Special Equipment Requested:			
# of nights staying in RCC:		*Note: Open 2nd & 4th Mondays (stay up to 72 hours)*	
If minor, parent's name & contact number:			
Scheduler's Name:			
Scheduler's Phone #:			