

Lowry Surgery Center

Scheduling Form

Office: 303-366-5656 Fax: 303-366-5657

*All Bold Areas are required.

***Today's Date:** _____ **Scheduler Name:** _____ **Surgeon:** _____

Patient Name: _____ **Patient Date of Birth:** _____

Patient Address: _____

City: _____ **State:** _____ **Zip:** _____ **SSN:** _____

Sex: Male ___ Female ___ **Phone:** (H) _____ (W) _____ © _____

Patient Email (optional): _____

Surgery Date: _____ **CPT Procedure Code(s):** _____

Proposed Procedures: _____

Diagnosis: _____

(circle) Left Right Bi-Lateral Upper Lower Front Back

Anesthesia: None / Local / IV Sedation / L-MAC / General Block

Anesthesia Provider: MDA CAC

Case Start: _____ **Case End:** _____ **Extended Care:** YES ___ NO ___

Latex Allergy: YES ___ NO ___

SPECIAL REQUESTS: (including: Implants, equipment, hardware, C-arm/Mini, Pathology services)

Special Patient Comments: (ie: allergies, wheel chair, interpreter etc...)

Primary Insurance: _____ **PCP Name:** _____

Member Number: _____ **Group Number:** _____ **Referral #** _____

Precert # _____ **Insurance Phone Number:** _____ **Employer Name:** _____

Secondary Insurance: _____ **Policy Number:** _____

Circle One: Workers Compensation / Auto Liability **Claim Number:** _____

Adjuster Name: _____ **Adjuster Phone Number:** _____ **Has Claim Been Filed Y / N**

CONFIRMATION # FOR OFFICE USE ONLY _____

Please Include a Copy of the Patients Insurance Card, Front and Back.