

# Greater New Orleans Surgery Center

3434 Houma Blvd Ste 300 • Metairie, LA 70006

phone (504) 454-2017 • fax (504) 454-2142

## SCHEDULING INFO

Patient Name \_\_\_\_\_

Surgery Date \_\_\_\_\_ Surgery Time \_\_\_\_\_ Duration \_\_\_\_\_

Surgeon **Cousins / Willson / Zhuk** Scheduler's Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Anesthesia  General  MAC  Epidural  Bier Block  Inter Scalene Block  Other \_\_\_\_\_

Diagnosis \_\_\_\_\_ ICD-9 code \_\_\_\_\_

\_\_\_\_\_ ICD-9 code \_\_\_\_\_

Procedure \_\_\_\_\_ CPT code \_\_\_\_\_

\_\_\_\_\_ CPT code \_\_\_\_\_

Special Equipment:  Cryo  Indirect Laser  Endo Laser  Gas  (Circle one) Brilliant Blue / ICG

Other \_\_\_\_\_

Lenses \_\_\_\_\_

Anterior

A-Constant

Power

Pre op Info  Patient was sent for the following tests \_\_\_\_\_

Patient needs to be evaluated in person by Anesthesia

Patient was sent for medical clearance to Dr \_\_\_\_\_ MD is PCP or \_\_\_\_\_

suggested the following pre op tests from above doctor \_\_\_\_\_

### *Patient Information (can fax over your registration forms)*

Address \_\_\_\_\_  
street address city state zip

Telephone # \_\_\_\_\_ Sex  Male  Female  
Home Work Cell

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Telephone # \_\_\_\_\_

If this is a workers comp case? Date of Injury \_\_\_\_\_ Claim # \_\_\_\_\_

Carrier \_\_\_\_\_ Carrier phone # \_\_\_\_\_

### *Insurance (please include copy of cards)*

Primary \_\_\_\_\_ Telephone # \_\_\_\_\_

Policyholder \_\_\_\_\_ Relationship \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary \_\_\_\_\_ Telephone # \_\_\_\_\_

Policyholder \_\_\_\_\_ Relationship \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**Thank you for scheduling with us!**