SUMMIT SURGICAL CENTER, LLC

RESERVATION FORM
Scheduling Office Contact Info
Phone: 856-247-7801
Fax: 856-247-7818
Email: sscheduling@virtua.org

Date Reservation Received:		Change Form Received Date:
Booked By:		
Chart Pack: ❑ General ❑ Eye ❑ Pain ❑ GI		New Date:
Distribution: ❑ OR ❑ IV ❑ PA ❑ AD		

SURGERY INFORMATION

Surgeon:		**Office Contact:**
DOS:	Required Time:	**Laterality:** ❑ Left ❑ Right
	Requested Start Time:	❑ N/A ❑ Bilateral

Anesthesia Type: ❑ General ❑LOC MAC ❑ Local ❑ Block❑ Femoral ❑ Popiteal ❑ Interscalene ❑ Supraclavicular

CPT Codes:	
Procedure Name:	
Diagnosis:	**Dx Codes:**

OR Requirements : ❑ C-Arm ❑ Post Op X-Ray ❑ Laser ❑ Fusion ❑ Microscope ❑ Ultrasound

Special Needs/Equipment:

Implants:

Patient Alerts: ❑ Diabetic ❑ Pacemaker ❑ Latex Allergies ❑ MH History ❑ Special Needs:

❑ Translator Required (If Checked) : Language:	BMI:	Height:
		Weight:

DEMOGRAPHICS

Legal Name Last:		**First:**	**MI:**
DOB:	**Gender:** ❑ Male ❑ Female	**Street Address:**	
SSN:	**City:**	**State:**	**Zip:**
Guardian Name/Relationship/DOB:		**#1 Phone:** **Best Time to Call:** ❑ M ❑ H ❑ W	
PCP Name:		**#2 Phone:** **Best Time to Call:** ❑ M ❑ H ❑ W	

FINANCIAL

Primary Insurance ATTACH COPY OF INS. CARD		**Secondary Insurance** ATTACH COPY OF INS. CARD	
ID #:		**ID #:**	
Subscriber Name:		**Subscriber Name:**	
Relationship:		**Relationship:**	
DOB:	**SSN:**	**DOB:**	**SSN:**
Precert: ❑ N/R		**Precert:** ❑ N/R	
Employer:		**Employer:**	
WC & NF: Adjuster:	**Phone #:**	**DOI & State:**	