

**SURGERY CENTER OF VOLUSIA
REGISTRATION FORM**

***Note: Patient registration form must be received by noon TWO business days before scheduled procedure.

FAX (386) 760-8185

DATE OF PROCEDURE _____ TIME _____ LENGTH OF TIME _____

PROCEDURE: _____

CPT CODE(S) _____

ICD-9 CODE(S) _____

DOI _____ (circle one) AUTO WC OTHER

PHYSICIAN _____ CONTACT _____

FIRST NAME _____ MI _____ LAST _____

ADDRESS _____

CITY, STATE, ZIP _____ PHONE _____

D.O.B. _____ SEX _____ SSN _____

EMERGENCY CONTACT _____

INSURANCE #1: INSURED NAME _____ SSN _____

INS CARRIER: _____ POLICY #: _____ GROUP #: _____

CLAIM #: _____ ADJUSTER NAME / PHONE: _____

ADDRESS: _____ PHONE: _____

RELATIONSHIP OF PT TO INSURED: _____ **AUTH #:** _____

INSURANCE #2: INSURED NAME _____ SSN _____

INS CARRIER: _____ POLICY #: _____ GROUP #: _____

CLAIM #: _____ ADJUSTER NAME / PHONE: _____

ADDRESS: _____ PHONE: _____

RELATIONSHIP OF PT TO INSURED: _____ **AUTH #:** _____

GENERAL INSTRUCTIONS

ANESTHESIA: CHOICE _____ GENERAL _____ MAC _____ IV SEDATION _____
LOCAL ONLY _____ INTERSCALENE BLOCK _____ REGIONAL BLOCK _____

REFERRED PT TO: _____ **LABCORP** _____ **QUEST** _____ **OTHER** _____

Does the patient have an AICD? ___ YES ___ NO *If YES Cardiac Clearance needed

SPECIAL INSTRUCTIONS / EQUIPMENT

