

**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 #: _____

ADDRESS: _____ PHONE: _____

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

INSURANCE #2: INSURED NAME _____ SSN _____

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

ADDRESS: _____ PHONE: _____

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

PHYSICIAN'S ORDERS

PREOP IV MEDS: AMPICILLIN _____ GM ANCEF _____ GM CLINDAMYCIN _____ MG GENTAMYCIN _____ MG
LEVAQUIN _____ MG VANCOMYCIN _____ MG / _____ GM OTHER: _____

PREOP IM MEDS: PHENERGAN _____ MG MORPHINE _____ MG DEMEROL _____ MG
OTHER: _____

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

PREOP TESTS: U/A _____ CBC _____ EKG _____ CHEST X-RAY _____ PT/PTT _____ OTHER: _____

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

SCV TESTING: EKG _____ OTHER: _____

PREP / PREOP INSTRUCTIONS _____

SPECIAL INSTRUCTIONS / EQUIPMENT _____

PAIN PUMP _____ Does the patient have an AICD? _____ YES _____ NO *If YES Cardiac Clearance needed

PHYSICIAN SIGNATURE _____ **DATE** _____