

**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) _____

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 #:** _____

GENERAL INSTRUCTIONS

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** _____

SPECIAL INSTRUCTIONS / EQUIPMENT

PATIENT'S MEDICATIONS: _____

PAIN PUMP _____ PAID FOR IN OFFICE? _____ ALLERGIES _____

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

NURSE'S SIGNATURE _____ DATE _____