

Scheduling Booking Sheet

□ 1 st visit	□ 2 ^{na} visit	□ 3 ^{ra} visit	□ Reso	escheduled Patient		
Today's Date:	Surgeon:Scheduler:					
Patient Name (First, Middle, Last):						
DOB:	SSN(Required):		Sex:	□ Male □ F	emale	
Home: ()	Work: ()		Cell: ()			
Address:	City	<u> </u>	State:	Zip:		
Procedure Date:	Procedure Time:			Duration:		
CPT:	Description:					
ICD-9:			_	<u>-</u>		
Anesthesia Type (Circle One): Straight Local MAC with Retrobulbar MAC General LENSX = YES = NO Lenstar Measurements: = YES = NO Restor Lens: = YES = NO Toric Lens: = YES = NO						
Implant Needed/Information: Specify IOL:						
Equipment Needed:						
Patient has ICD or Defibrillator? YES NO (answer required) If "YES" EP Clearance is required. Use "ICD Patient Clearance Form"						
Is power of attorney required for this patient? (answer required) PH#: PH#:						
Is a translator required for this patient?(answer required) □ YES □ NO If "YES" Language:						
Primary Insurance Information: Plan: Group No: Insured ID No: Pre-Cert/Referral/Notification No (if applicable):						
Secondary Insurance Information: Plan: Group No: Insured ID No: Pre-Cert/Referral/Notification No (if applicable):						

□ Signed HIPPA Release on file □ Patient has been provided with information regarding physician ownership, patient rights & responsibilities, and advanced directives