

EMU Surgical Center
Surgical Scheduling Form

Email: rmanrakhan@emuhealth.com **Phone:** (718) 849-8700 / **Fax:** (718) 849-6523



Patient Demographics

Last Name	First Name	MI	Gender	Date of Birth	Age
Address					
SS#	Main Phone	Secondary Phone			
Special Needs? Please list.	Allergies? (Y / N) Please list.	Interpretation Services Needed?			

Surgery Information

Date	Requested time	Surgery Length (mins)	R /L /Bil	Admitting Physician
Anesthesia Type: Gen / MAC / Local	BMI or H/W	Special Equipment/Implants		
Procedure #1	CPT	ICD		
Procedure #2	CPT	ICD		
Procedure #3	CPT	ICD		
PAT: EMU / PCP / Surgeon	Date/Time			

Insurance Information (Please attach copy of front/back of insurance card)

Primary Insurance	Policy #	Policy Holder's Name
Secondary Insurance	Policy #	Relation to Patient
Auth #	Auth Comments	
PCP Name	Phone	
Date of Accident	Attorney	Phone

Scheduler	Phone
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