

TURTLE CREEK SURGERY CENTER, LLC

801 Turtle Creek Drive
Tyler, Texas 75701
Phone: (903) 526-8272
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OUTPATIENT SURGERY INFORMATION

CANCEL RESCHEDULE From: _____ To: _____

Surgery Date: _____ Surgery Time: _____ Length of Time: _____

Surgeon: _____ Assistant Surgeon: _____

Anesthesia: M.D. CRNA Request: _____

Patient's Full Name: _____ Date of Birth: __/__/__ Age __ male/female

Address: _____ Home Telephone #: _____

Patient's Social Security Number: ____ - ____ - ____ Work Number: _____

Diagnosis: _____

Surgical Procedure: _____

Comments: _____

Current Medications: _____ Allergies: _____ NKA

Diet Pills: Yes No Blood Thinners: Yes No ASA/Arthritis Yes No Diabetic Yes No

INSURANCE INFORMATION (whenever possible please send a copy of insurance cards)

Medicare: _____ Part A/B: _____ Medicaid: _____

Insurance Company: _____ Precert Number: _____

Responsible Party: _____

Workmen's Compensation Carrier: _____ Case #: _____

Address: _____ Date of Injury: __/__/__

Employer: _____

Private Pay – Responsible Party: _____

Date Surgery Scheduled: __/__/__ Scheduled by: _____ Scheduled with: _____

Confirmed with patient: __/__/__ By: _____