



# Scheduling Request

PHYSICIANS SURGICAL HOSPITALS, L.L.C.

Panhandle Surgical Hospital Fax: (806) 212-0294

PANHANDLE SURGICAL HOSPITAL

QUAILCREEK SURGICAL HOSPITAL

Quail Creek Surgical Hospital Fax: (806) 354-6162

TO: \_\_\_\_\_ DATE: \_\_\_\_\_  
 FAX: \_\_\_\_\_ FROM: \_\_\_\_\_  
 PHONE: \_\_\_\_\_ OFFICE: \_\_\_\_\_  
 PAGES: \_\_\_\_\_ PHONE: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Sex: Male Female

Surgeon: \_\_\_\_\_ Type of Anes: \_\_\_\_\_

Procedure: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Requested\* \_\_\_\_\_ Estimated \_\_\_\_\_  
 Date: \_\_\_\_\_ Time: \_\_\_\_\_ Duration: \_\_\_\_\_ Length of Stay: \_\_\_\_\_

*\* The requested Date and Time of the procedure is tentative until confirmed by Physicians Surgical Hospital's Scheduling Department.*

**PLEASE ATTACH A COPY (FRONT & BACK) OF THE PATIENT'S INSURANCE CARD**

**Please Complete the Following OR Attach Demographic Information**

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Guarantor Name (If Minor): \_\_\_\_\_ Phone: \_\_\_\_\_

Is this a Work Related Injury?  Yes  No

If yes, Date of Injury: \_\_\_\_\_

Is Employer a TWCC Subscriber?  Yes  No

Is this a Motor Vehicle Accident?  Yes  No

If yes, Date of Injury: \_\_\_\_\_

Driver at Fault: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Benefit Phone: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Group #: \_\_\_\_\_

Network: \_\_\_\_\_ Adjuster/Case Mgr: \_\_\_\_\_

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