PHYSICIANS SURGICAL HOSPITALS, LLC
PANHANDLE SURGICAL HOSPITAL QUAILCREEK SURGICAL HOSPITAL

Scheduling Request

Panhandle Surgical Hospital Fax: (806) 212-0294
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* Date: _____ **Time:** _____ **Estimated 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: _____