

**BAYLOR MEDICAL CENTER AT FRISCO**  
**SURGERY SCHEDULING FORM**  
**FAX: 214-407-5125**

Patient Name: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_ Time of Surgery: \_\_\_\_\_

Surgeon Name: \_\_\_\_\_ Anesthesiologist: \_\_\_\_\_

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

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

Pre-Op Diagnosis: \_\_\_\_\_ Codes: \_\_\_\_\_

Frozen Section Request  Yes  No

Grafts/Tissue Requested  Yes  No

Grafts/Tissue Specifications (Size/Width/Length): \_\_\_\_\_

Special Needs/Requests: \_\_\_\_\_

Instrumentation to be Delivered/Vendor Name and Phone No: \_\_\_\_\_

Patient Status:  SDC  23 Obs  IP Procedure Length: \_\_\_\_\_

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Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Gender:  M  F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell # or Other Contact #: \_\_\_\_\_

Social Security#: \_\_\_\_\_ Insurance Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Insurance Phone#: \_\_\_\_\_ Precert/Authorization #: \_\_\_\_\_

Policy#: \_\_\_\_\_ Insured: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured Employer Name & Address: \_\_\_\_\_

Person Calling: \_\_\_\_\_ Date/Time of call: \_\_\_\_\_ Scheduler Initials: \_\_\_\_\_

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