



Today's Date : _____

ORTHOGNATHIC SCHEDULING SHEET

Bend

Redmond

Prineville

Madras

Fax: 541-706-6342
Phone: 541-706-7788

Fax: 541-526-6568
Phone: 541-526-6503

Fax: 541-416-9942
Phone: 541-447-8346

Fax: 541-460-4070
Phone: 541-460-4083

PATIENT INFORMATION

Patient Last Name: _____ First Name: _____ MI: _____
 DOB: _____ Gender: Female Male Last Four Digits Of SSN: _____
 Patient Address: _____ City: _____ St: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Pt. Preferred Number: Home Cell Work Best Time To Call Pt: Morning Afternoon Evening
 Interpreter Needed: Yes No Language: _____
 Insurance Company Name: _____ Policy # _____
 Medicare: Yes No Authorization / Pre Certification Number: _____

SURGERY INFORMATION

Surgery Date: _____ Surgeon: _____ Assistant: _____
 Secondary Surgeon: _____
 Surgeon's Scheduler Name: _____ Direct Phone: _____
 ICD(s): _____ CPT(s): _____
 Working Diagnosis: _____
 Procedure: Left Right Bilateral _____

Inpatient / Outpatient / Current In Patient - Room #: _____ Time Required (Cut to Close): _____
 Position For Surgery: Supine / Lateral / Beach Chair / Prone / Sitting / Other: _____
 Approach: Laparoscopic Open
 Anesthesia: General / Spinal / MAC / Local / Bier / Moderate Sedation / Other: _____
 Instrumentation: _____
 Special Order - Type: _____ Size: _____ Manufacturer: _____
 Vendor Rep Notified: Yes No Rep Name: _____ Phone #: _____
 Implant: _____ Implant Authorization No. _____

Medical Pre-Op With: _____ Date: _____ Time: _____
 Pre-Op With Surgeon Date: _____ Time: _____

MISC. SCHEDULING INFORMATION

