Opelousas General Health System
Central Scheduling Checklist (CSC01)

Current Date: ____________________

Physician: ____

Contact Name: ____

Contact Phone #: ____________________

Surgery Date: ____________________ **Surgeon:** ____________________

Procedure: ______________________________ **Dx:** ____________________

Patient Name: ______________________________ **DOB:** __________ **Age:** ________

Patient Address: ____
Mailing Address City State Zip

Sex _____ **SS#** ______________ **Work #** ______________ **Home#** ____________ **Cell #** ____________

Nearest Relative or Friend not living with you: ______________________________ **Phone #** ____________

Marital Status: (Circle One) Married Single **Referring Physician:** ____________________

Employer: ____________________ **Employer Address:** ____________________

Parent's Name: (If patient is a child) ____

Type of Injury: (Circle One) Motor Vehicle Accident Injured on the Job Liability Other Injury Not an Injury

Date of Injury: (if applicable) ______________

<u>Please Complete Guarantor Information (if patient is not guarantor)</u>

Guarantor (Responsible Party): ______________________________ **DOB** ____________

Guarantor Address: ____
Mailing Address City State Zip

Sex _____ **SS#** ______________ **Work #** ______________ **Home#** ____________ **Cell #** ____________

Employer: ____________________ **Employer Address:** ____________________

Pre-Cert# ____________________ **PCP Referral#** ____________________

ATTACHED

1 - Copies of all insurance cards, front and back

2 - PCP Referral Form