35-800 Bob Hope Drive Suite 100
Rancho Mirage, CA 92270

I, ____, have been informed of the Patient's Rights, Patient's Responsibilities', Notice of Significant Beneficial Interest, Advance Directive, and HIPAA Notice of Privacy (Lime Green Notice). My signature indicates that I received and understand this information prior to the date of surgery at Rancho Mirage Surgery Center

____ ____________________________

Patient/Responsible Party Signature Date

DATE OF SURGERY: ___________________________

PATIENTS NAME: ____

DOB :_____________________________________( ) **MALE** ( ) **FEMALE**

SSN: ____ **PHONE #** _________________________________

SURGEON: __________________________________ **RNFA/PAC IF NEEDED:** ________________________

SPECIAL EQUIPMENT NEEDED: **PLEASE SEE ATTACHMENT**

PROCEDURE CODE: ____

PROCEDURE:____

____

DIAGNOSIS CODE: ____

DIAGNOSIS: ____

ANESTHESIA: ( ) **GENERAL** ( ) **MAC** ( ) **LOCAL** ( ) **BLOCK** **OTHER**________________

REQUESTED START TIME: ________________________

DURATION: ___________________________________ **ALLERGIES:** ______________________

DEMOGRAPHICS ATTACHED: ( ) **YES** ( ) **NO**

INSURANCE INFORMATION/COPY OF INSURANCE CARDS ATTACHED: ( ) **YES** ( ) **NO**

PRE-OP LABS AND RADIOLOGY ORDERS REQUIRED FOR SURGERY:

***TESTS ORDERED:** __BMP__CBC__PT__PTT__SGOT__HGC__CXR__EKG__NO TEST REQUIRED