Trinity Plaza Surgery Center
10200 Trinity Parkway Suite 101
Stockton, CA 95219

Phone: 209-323-3480
Fax: 209-472-9102

Scheduling Referral Form

PROCEDURE

Doctor:

Date and Time of Surgery/Exam:

Duration of Procedure: _____ **H**ours _____ Minutes

Type of Surgery:

Admitting Diagnosis with ICD-9 code:

Additional Surgeries:

CPT code(s):

PATIENT

Patient Name: _____
Last First

DOB: _____/_____/_____

Circle One
SEX: M F

Patient Address: _____
Street City State Zip

SSN: _____-_____-_____

Patient Telephone:

_____ _____ _____
Work Home Cell

Please Circle One
Best Time to Call Patient for Pre-Admit Call: ☐ Morning ☐ Afternoon ☐ Evening @ WORK HOME CELL

INSURANCE (or fax insurance card)

Subscriber Name: _____
Last First

DOB: _____/_____/_____

Relationship to Patient:

Subscriber SSN: ____-____-_____

Subscriber #: _____

Group #: _____

Insurance Carrier:

Ext. Reference/Pre-Cert/Auth Number:

Insurance Address:
_____
Street City State Zip

OTHER INSURANCE (or fax insurance card)

Seconday Insurance? ☐ **Yes** ☐ **No**

DOB: _____/_____/_____

Subscriber Name: _____
Last First

Relationship to Patient:

Subscriber SSN: ____-____-_____

Subscriber #: _____

Group #: _____

Insurance Carrier:

Ext. Reference/Pre-Cert/Auth Number:

Insurance Address:
_____
Street City State Zip

Referring Physician

Referring Physician:	Phone Number:	Fax Number:

SPECIAL INSTRUCTIONS

NOTE:

PLEASE FAX WITH HISTORY AND PHYSICAL, PATIENT'S FACE SHEET, AND INSURANCE CARD TO:
209-472-9102