

# SURGERY SCHEDULING FORM

Patient Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_

## Patient Information:

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Emergency Contact:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Insurance Information:

Provider Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

## Scheduling Details:

Requested Surgery Date & Time: \_\_\_\_\_

Surgeon: \_\_\_\_\_

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

Anesthesia Type: \_\_\_\_\_

## Pre-Operative Instructions:

Patient must follow all pre-operative instructions provided by the surgical team, including fasting requirements, medication adjustments, and hygiene protocols. Failure to comply may result in rescheduling or cancellation of the surgery.

## Post-Operative Care and Instructions:

Patient agrees to follow all post-operative care instructions, attend follow-up appointments, and immediately report any complications or concerns to the healthcare provider. Failure to comply may affect recovery and legal responsibility.

## Patient Consent and Agreement:

By signing below, Patient consents to the scheduled surgery and related medical procedures, acknowledges understanding of risks and benefits, and agrees to comply with all pre- and post-operative instructions. Patient authorizes healthcare providers to perform the surgery and provide necessary care. This document shall be governed by and construed in accordance with the laws of the United States.

## Legal Disclosures and Limitations:

The Patient acknowledges that no guarantees have been made regarding the outcome of the surgery. The healthcare provider shall not be held liable for unforeseeable complications or adverse effects arising from the procedure, except in cases of gross negligence or willful misconduct as defined by applicable law.

**PATIENT SIGNATURE**

**SURGEON SIGNATURE**

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

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