

**PHYSICIANS ENDOSCOPY CENTER**  
3030 S. Gessner  
Suite 150  
Houston, Texas 77063



### **OPEN ACCESS COLONOSCOPY SCHEDULING FORM**

Scheduling Fax (713) 587-0912

Scheduling Phone (713) 587-0909, X131

Preferred Procedure Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Preferred Time: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
(Last) (First) (MI)

Address: \_\_\_\_\_  
(Address, City, State & Zip)

Home # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_

Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ PCP's Name: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

#### **PRIMARY INSURANCE**

Insurance Name: \_\_\_\_\_ Benefits Phone #: (\_\_\_\_) \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

#### **SECONDARY INSURANCE**

Insurance Name: \_\_\_\_\_ Benefits Phone #: (\_\_\_\_) \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

#### **SCHEDULERS USE ONLY**

Date of Procedure: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ Physician: \_\_\_\_\_

Procedure (CPT Code): \_\_\_\_\_ Diagnosis (ICD-9 Code): \_\_\_\_\_

Patient ID#: \_\_\_\_\_ Patient Acct#: \_\_\_\_\_

Pre-Cert Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Contact: \_\_\_\_\_ Auth #: \_\_\_\_\_

Scheduled By: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_