

## **PRE-OP PHYSICAL INFORMATION**

FAX BACK TO Dr. Julius DeBroeck, M.D at  
281-469-6213

Please provide the following information prior to your pre-op clearance appointment:

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

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

Planned date of surgery: \_\_\_\_\_

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

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

Surgeon City/St/Zip: \_\_\_\_\_

Surgeon Office Phone: \_\_\_\_\_

Surgeon Office Fax: \_\_\_\_\_

Surgeon NPI #: \_\_\_\_\_  
(obtain from surgeon's office)

Surgeon UPIN #: \_\_\_\_\_  
(obtain from surgeon's office)

ICD-9 Diagnosis code for surgery: \_\_\_\_\_  
(obtain from surgeon's office)

Description of code: \_\_\_\_\_  
(obtain from surgeon's office)

Pre-Op Clearance letter needed?            Y    N

Pre-Op Clearance letter done: (date) \_\_\_\_\_