SURGICARE
Ambulatory Surgery Center of New York

SCHEDULING OFFICE:
TEL (718) 518-9000 ext 223 • FAX (718) 518-7821

SURGICAL BOOKING FORM

PATIENT INFORMATION

NAME LAST | FIRST | MI | AGE | M ☐ F ☐ | DOB

STREET | SSN

CITY | STATE | ZIP | EMERGENCY CONTACT

TELEPHONE NUMBERS (PLEASE PROVIDE ALL)

HOME | WORK | CELL | EMERGENCY

SURGICAL PROCEDURE INFORMATION

SURGEON: Dr. Gabriel Dassa | ASSISTING SURGEON

REQUEST DATE #1 TIME | REQUEST DATE #2 TIME | LENGTH OF CASE | ANESTHESIA TYPE: GENERAL ☐ REGIONAL (BLOCK) ☐ MAC ☐ LOCAL ☐

PRIMARY PROCEDURE NAME	LEFT ☐ RIGHT ☐	CPT CODE 1	CPT CODE 2	CPT CODE 3	CPT CODE 4	CPT CODE 5	CPT CODE 6
SURGICAL DIAGNOSIS NAME	LEFT ☐ RIGHT ☐	ICD-9 CODE 1	ICD-9 CODE 2	ICD-9 CODE 3	ICD-9 CODE 4	ICD-9 CODE 5	ICD-9 CODE 6

PREOPERATIVE MEDICAL CLEARANCE

DOES THE PATIENT REQUIRE PREOP MEDICAL CLEARANCE? YES ☐ NO ☐ | IF YES, NAME OF CLEARING PHYSICIAN AND TELEPHONE NUMBER

DOES THE PATIENT REQUIRE AN EKG? YES ☐ NO ☐ | PATIENT HEIGHT | WEIGHT

SPECIAL REQUESTS

EQUIPMENT | SUPPLIES

INSTRUMENTATION | OTHER

INSURANCE INFORMATION

PRIMARY INSURANCE | SUBSCRIBER NAME | SUBSCRIBER SSN | SUBSCRIBER DOB

POLICY NUMBER | RELATIONSHIP TO PATIENT: SELF ☐ SPOUSE ☐ PARENT ☐ OTHER ☐

SECONDARY INSURANCE | SUBSCRIBER NAME | SUBSCRIBER SSN | SUBSCRIBER DOB

POLICY NUMBER | RELATIONSHIP TO PATIENT: SELF ☐ SPOUSE ☐ PARENT ☐ OTHER ☐

IS THIS WORKMAN'S COMP? YES ☐ NO ☐
IS THIS NO FAULT? YES ☐ NO ☐
PLEASE ATTACH AUTHORIZATION LETTER | CASE CLAIM NUMBER | DATE OF INJURY

EMPLOYER NAME | EMPLOYER ADDRESS | EMPLOYER PHONE

IS THIS A LIEN? YES [ ] NO [ ]
PLEASE ATTACH SIGNED LIEN | ATTORNEY NAME | ATTORNEY PHONE

INSURANCE PRECERTIFICATION AUTHORIZATION

INSURANCE COMPANY PHONE | INSURANCE CO. REPRESENTATIVE | AUTHORIZATION NUMBER | DATE OF AUTHORIZATION

SURGEON'S SCHEDULER'S INFORMATION

NAME | PHONE NUMBER

PLEASE FAX A COPY OF THE FRONT AND BACK OF THE PATIENT'S INSURANCE CARD.

FORM REV 1/26/06