ASC of Rockaway

Phone: 718-819-5448 Fax: 718 945-8792

SURGICAL BOOKING FORM

PATIENT INFORMATION

LAST NAME	FIRST NAME	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	ASSISTING SURGEON

REQUEST DATE #1	TIME	REQUEST DATE #2	TIME	LENGTH OF CASE	ANESTHESIA TYPE
					GENERAL ☐ MAC ☐ REGIONAL ☐ 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-10 CODE 1	ICD-10 CODE 2	ICD-10 CODE 3	ICD-10 CODE 4	ICD-10 CODE 5	ICD-10 CODE 6

PREOPERATIVE MEDICAL CLEARANCE

DOES THE PATIENT REQUIRE PRE-OP 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 WORKERS COMP? YES ☐ NO ☐ IS THIS NO FAULT? YES ☐ NO ☐	CASE CLAIM NUMBER	DATE OF INJURY

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER

IS THIS A LIEN? YES ☐ NO ☐ **PLEASE ATTACH SIGNED LIEN**	ATTORNEY NAME	ATTORNEY PHONE

INSURANCE PRECERTIFICATION AUTORIZATION

INSURANCE CO. PHONE	INSURANCE CO. REPRESENTATIVE	AUTORIZATION NUMBER	DATE OF AUTORIZATION

SURGEON'S SCHEDULER'S INFORMATION

NAME	PHONE NUMBER

Patient Information

Personal Information

First Name		**Middle Name**	
Last Name		**D.O.B**	
Gender		**Address**	
City		**State**	
Cell Phone #		**Home Phone**	
Work		**Zip**	
Email		**Extn.**	
Attorney		**Case Type**	
Attorney Address		**Attorney Phone**	
Case Status		**SSN**	

Insurance Information

Policy Holder		**Name**	
Address		**City**	
State		**Zip**	
Phone		**Fax**	
Contact Person		**Claim File #**	
Policy #		**WCB Group**	

Accident Information

Accident Date		**Plate Number**	
Report Number		**Address**	
City		**State**	
Hospital Name		**Hospital Address**	
Date of Admission		**Additional Patient**	
Describe Injury		**Patient Type**	

Employer Information

Name		**Address**	
City		**State**	
Zip		**Phone**	
Date of First Treatment		**Chart #**	

Adjuster Information

Name		**Phone**	
Extension		**Fax**	
Email			