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
txt_lname|LastName	txt_fname|FirstName	txt_mname|MiddleN	txt_ag	☐ ☐	txt_dob|DOB

STREET	SSN
txt_address|Address1	txt_ssn|SSN

CITY	STATE	ZIP	EMERGENCY CONTACT
txt_city|City	txt_state|State	txt_zip|Zip	

TELEPHONE NUMBERS (PLEASE PROVIDE ALL)

HOME	WORK	CELL	EMERGENCY
txt_Phone2|Phone	txt_work_phone|work_phone	txt_mob|Phone2	

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
txt_InsCo|InsCo		txt_ssn|SSN	txt dob|DOB

POLICY NUMBER	RELATIONSHIP TO PATIENT SELF ☐ SPOUSE ☐ PARENT ☐ OTHER ☐
txt_policy_no|policy_no	

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
	txt_ClaimNumber|ClaimNumber	txt_doa|DOA

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER

IS THIS A LIEN? YES ☐ NO ☐ PLEASE ATTACH SIGNED LIEN	ATTORNEY NAME	ATTORNEY PHONE
	txt_attorney|Attorney	txt attorneyPhno|AttorneyPhno

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	txt_fname|FirstName	**Middle Name**	txt_mname|MiddleName
Last Name	txt_lname|LastName	**D.O.B**	txt_dob|DOB
Gender	txt_sex|Sex	**Address**	txt_address|Address1
City	txt_city|City	**State**	txt_state|State
Cell Phone #	txt_mob|Phone2	**Home Phone**	txt_Phone2|Phone
Work	txt_work_phone|work_phone	**Zip**	txt_zip|Zip
Email	txt_eMail|EmailAddress	**Extn.**	
Attorney	txt_attorney|Attorney	**Case Type**	txt_casetype|WCBGroup
Attorney Address	txt_attorneyAdd|AttorneyAdd	**Attorney Phone**	txt_attorneyPhno|AttorneyPhno
Case Status		**SSN**	txt_ssn|SSN

Insurance Information

Policy Holder	txt_name123|patientfullname	**Name**	txt_InsCo|InsCo
Address	txt_Insaddress987|InsAddress1	**City**	txt_Inscity|InsCity
State	txt_Insstate987|InsState	**Zip**	txt_Inszip|Inszip
Phone	txt_InsPhone987|InsPhone	**Fax**	
Contact Person		**Claim File #**	txt_ClaimNumber|ClaimNumber
Policy #	txt_policy_no|policy_no		

Accident Information

Accident Date	txt_doa|DOA	**Plate Number**	
Report Number		**Address**	
City		**State**	
Hospital Name		**Hospital Address**	
Date of Admission	txt_doe12|LASTDOE	**Additional Patient**	
Describe Injury		**Patient Type**	

Employer Information

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

Adjuster Information

Name	txtAdjuster|AdjUserName	**Phone**	txtAdjusterph|AdjPhone
Extension		**Fax**	
Email			