Printed on : **txt_date**

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|EmpAddress**
City	**txt_city|City**	**State**	**txt_state|State**
Cell Phone #	**txt_mob**	**Home Phone**	**txt_Phone2|Phone**
Work	**txt_work_phone|work_phone**	**Zip**	**txt_zip|Zip**
Email	**txt_eMail|eMail**	**Extn.**	**Text12**
Attorney	**txt_attorney|Attorney**	**Case Type**	txt_casetype
Attorney Address	txt_attorneyAdd|AttorneyAdd	**Attorney Phone**	**txt_attorneyPhno|AttorneyPhno**
Case Status	**Text17**	**SSN**	**txt_ssn|SSN**

Insurance Information			
Policy Holder	txt_name123|EmpName	**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**	Text21
Contact Person	Text21126	**Claim File #**	**txt_ClaimNumber|ClaimNumber**
Policy #	**txt_policy_no|policy_no**		

Accident Information			
Accident Date	**txt_doa|DOA**	**Plate Number**	Text215
Report Number	Text211	**Address**	txt_address12
City	txt_city12	**State**	txt_state12
Hospital Name	Text212	**Hospital Address**	Text216
Date of Admission	txt_doe12	**Additional Patient**	Text217
Describe Injury	Text214	**Patient Type**	Text218

Employer Information			
Name	Text22	**Address**	**Text26**
City	**Text23**	**State**	**Text27**
Zip	**Text24**	**Phone**	**Text28**
Date of First Treatment	**Text25**	**Chart #**	**Text29**

Adjuster Information			
Name	txtAdjuster|Adjuster	**Phone**	txtAdjusterph
Extension	txtAdjusterext	**Fax**	**Text31**
Email	txtAdjusteremail		

CITIMED SURGERY CENTER
92-12 165th St, Jamaica, NY 11433
Phone: 201-549-9998 Ext. 1279 Fax: 646-585-4468
Email: verification@starssi.com

Patient Email: txt_eMail|eMail

Surgical Booking Form

Patient Information

LAST	FIRST	MI		DOB	AGE
txt_lname|LastName	txt_fname|FirstNam	txt_mname|Mid	txt_ M ☐ F	txt_dob|DOB	txt_age|AGE

STREET ADDRESS	SOCIAL SECURITY #
txt_address|EmpAddress	txt_ssn|SSN

CITY	STATE	ZIP	EMERGENCY CONTACT
txt_city|City	txt_state|S	txt_zip|Zip	Text10

HOME #	WORK #	CELL #	EMERGENCY #
txt_Phone2|Phone	txt_work_phone|wor	txt_mob	Text11

Surgical Procedure Information

SURGEON	ASSISTING SURGEON
Dr. Anjani Sinha	Text12

REQUEST DATE #1	TIME	REQUEST DATE #2	TIME	LENGTH OF CASE
txtproc_code_d	Text14	Text15	Text16	Text17

PRIMARY PROCEDURE NAME	☐ LEFT ☐ RIGHT	CPT CODE #1	CPT CODE #2	CPT CODE #3	CPT CODE #4
txt_Procedure_Code		Text23	Text24	Text25	Text26

SURGICAL DIAGNOSIS NAME	☐ LEFT ☐ RIGHT	ICD-9 CODE #1	ICD-9 CODE #2	ICD-9 CODE #3	ICD-9 CODE #4
txt_diag		Text27	Text28	Text29	Text30

Pre-Operative Medical Clearance

DOES THE PATIENT REQUIRE PRE-OP MEDICAL CLEARANCE? ☐ YES ☐ NO	IF YES, NAME OF CLEARING PHYSICIAN AND PHONE #:
	Text31

DOES THE PATIENT REQUIRE AN EKG? ☐ YES ☐ NO	PATIENT HEIGHT	PATIENT WEIGHT
	Text32	Text33

Special Requests

EQUIPMENT	SUPPLIES
Text34	Text35

INSTRUMENTATION	OTHER
Text37	Text36

Insurance Information

IS THIS WORKMAN'S COMP? ☐ YES ☐ NO	PLEASE ATTACH AUTHORIZATION LETTER	CASE CLAIM #	DATE OF INJURY
IS THIS NY NO FAULT? ☐ YES ☐ NO		txt_ClaimNumber|Claiml	txt_doa|DOA
IS THIS PRIVATE HEALTH INS? ☐ YES ☐ NO			

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

PRIMARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB
txt_InsCo|InsCo	txt_subname	txt_subssn	txt_subdob

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

SECONDARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB
Text55	Text56	Text57	Text58

POLICY #	RELATIONSHIP TO PATIENT
Text64	☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE #
Text65	Text74	Text59

Insurance Pre-Certification Authorization

INSURANCE COMPANY PHONE #	INSURANCE CO. REPRESENTATIVE	AUTH #	DATE OF AUTH.
Text66	Text67	Text61	Text60

Surgeon's Scheduler's Information

NAME	PHONE #	FAX #
Sekina Amirova	347-433-4855	929-333-7950

Treating Physical Therapy Office

NAME	PHONE #	ADDRESS
Text70	Text71	Text63

Transportation: ☐ YES ☐ NO