

Patient Information

Personal Information			
First Name	EMILY	Middle Name	-
Last Name	EDWARDS	D.O.B	01/24/2003
Gender	Female	Address	423 SOUTH FULLTON AVE APT3
City	MOUNT VERNON	State	NEW YORK
Cell Phone #	347-206-6391	Home Phone	718-881-5845
Work	-	Zip	10553
Email	-	Extn.	-
Attorney	DOMINICK LAVELLE	Case Type	No-Fault
Attorney Address	100 HERRICKS ROAD SUITE 201	Attorney Phone	800-745-4878
Case Status	OPEN	SSN	-

Insurance Information			
Policy Holder	-	Name	LIBERTY MUTUAL INS.
Address	P.O. Box# 1052	City	Montgomeryville
State	PENNSYLVANIA	Zip	18936-1052
Phone	800 245-1700	Fax	-
Contact Person	-	Claim File #	034381648
Policy #	AOS228001979405		

Accident Information			
Accident Date	09/14/2016	Plate Number	-
Report Number	-	Address	-
City	-	State	-
Hospital Name	-	Hospital Address	-
Date of Admission	-	Additional Patient	-
Describe Injury	-	Patient Type	Passenger

Employer Information			
Name	-	Address	-
City	-	State	-
Zip	-	Phone	-
Date of First Treatment	-	Chart #	-

Adjuster Information			
Name	-	Phone	-
Extension	-	Fax	-
Email	-		

Fifth Ave Surgery Center Extension Clinic

305 East 47th Street New York, NY 10017

Tel.: (646) 233-5000

Office Fax: (646) 233-5001

Patient Booking Form

☐ Medicare/Medicaid ☐ Private/Commercial ☐ NJPIP ☐ NYNF ☐ WC ☐ Legal Funding ☐ Self-Pay

**** MUST FAX BACK WITH LEGIBLE COPY OF PATIENT'S INSURANCE CARD: FRONT & BACK ****

Today's Date:		Previous Admission: Yes <input type="radio"/> No <input type="radio"/>	
Patient's Name:		Patient's Social Security #	
Patient's Gender: M <input type="radio"/> F <input type="radio"/>	Patient's Date of Birth: / /		
Patient's Home Address:			
City:	State:	Zip Code:	
Home Phone #	Work Phone #	Cell Phone #	
Notify In Case of Emergency:	Phone #	Relationship:	
Primary Insurance:		Claims Address:	
Insurance Co. Phone #:		Adjuster:	
Policy ID #	Claim #	DOA/DOL:	
Secondary Insurance:		Claims Address:	
Insurance Co. Phone #:		Adjuster:	
Policy ID #	Claim #	DOA/DOL:	
Attorney's Name:		Attorney's Phone #:	
NB ALL PRIVATE INSURANCE/WORKERS' COMP/PIP CASES MUST HAVE PRIOR AUTHORIZATION FOR APPROVED TREATMENT			
Admitting Diagnosis: M23.92			
Proposed Procedure: Left Knee Arthroscopy - 29876, 29874, 29880			
Referring Physician:		Referring Clinic:	Phone #:
Admitting Surgeon: Dr. Anjani Sinha		Contact Person at Clinic: Eric - 718-886-2011	
Proposed Surgery Date: / /		Proposed Time of Surgery:	
Anesthesia Type:		Estimated Surgery Duration:	
Surgeon Requires Assistant:		Specific Supplies and/or Equipment:	
Patient Needs Transportation: Yes <input checked="" type="checkbox"/> No <input type="radio"/>			
Note Pick Up Address if Different from Home (Above):			
Affirmation By Medical Staff that He/She has Explained Proposed Procedure to the Patient to the Fullest Extent Possible By State Law			
Medical Staff's Signature:		Patient's Signature:	