Printed on: 10/18/2017

## **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

Patient Booking Form

Tel.: (646) 233-5000

Office Fax: (646) 233-5001

## ☐ 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: Yes • No O Previous Admission: Patient's Name: Patient's Social Security # Patient's Gender: M O FO 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: M23.91 Proposed Procedure: Right Knee Arthroscopy - 29880, 29876, 29874 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: Yes 🗶 No O Patient Needs Transportation: 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: