Printed on :

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 #			

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			

SURGICARE OF BROOKLYN

313 43rd St, Brooklyn, NY 11232
Phone: 201-549-9998 Ext. 1279 Fax: 646-585-4468
Email: verification@starssi.com

Patient Email: _____

Surgical Booking Form

Patient Information

LAST	FIRST	MI	M F	DOB	AGE
STREET ADDRESS				SOCIAL SECURITY #	
CITY	STATE	ZIP	EMERGENCY CONTACT		
HOME #	WORK #	CELL #	EMERGENCY #		

Surgical Procedure Information

SURGEON Dr. Anjani Sinha			ASSISTING SURGEON		
REQUEST DATE #1	TIME	REQUEST DATE #2	TIME	LENGTH OF CASE	
PRIMARY PROCEDURE NAME	LEFT RIGHT	CPT CODE #1	CPT CODE #2	CPT CODE #3	CPT CODE #4
SURGICAL DIAGNOSIS NAME	LEFT RIGHT	ICD-9 CODE #1	ICD-9 CODE #2	ICD-9 CODE #3	ICD-9 CODE #4

Pre-Operative Medical Clearance

DOES THE PATIENT REQUIRE PRE-OP MEDICAL CLEARANCE? YES NO	IF YES, NAME OF CLEARING PHYSICIAN AND PHONE #:	
DOES THE PATIENT REQUIRE AN EKG? YES NO	PATIENT HEIGHT	PATIENT WEIGHT

Special Requests

EQUIPMENT	SUPPLIES
INSTRUMENTATION	OTHER

Insurance Information

IS THIS WORKMAN'S COMP? YES NO IS THIS NY NO FAULT? YES NO IS THIS PRIVATE HEALTH INS? YES NO	**PLEASE ATTACH AUTHORIZATION LETTER**	CASE CLAIM #	DATE OF INJURY
IS THIS A LIEN? YES NO **PLEASE ATTACH SIGNED LIEN**	ATTORNEY NAME		ATTORNEY PHONE #
PRIMARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB
POLICY #	RELATIONSHIP TO PATIENT SELF SPOUSE PARENT OTHER		
SECONDARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB
POLICY #	RELATIONSHIP TO PATIENT SELF SPOUSE PARENT OTHER		
EMPLOYER NAME	EMPLOYER ADDRESS		EMPLOYER PHONE #

Insurance Pre-Certification Authorization

INSURANCE COMPANY PHONE #	INSURANCE CO. REPRESENTATIVE	AUTH #	DATE OF AUTH.

Surgeon's Scheduler's Information

NAME	PHONE #	FAX #

Treating Physical Therapy Office

NAME	PHONE #	ADDRESS

Transportation:
X☐ YES ☐ NO