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|Address1
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	**Name**	txt_InsCo|InsCo
Address	txt_Insaddress987	**City**	txt_Inscity|InsCity
State	txt_Insstate987	**Zip**	txt_Inszip|Inszip
Phone	txt_InsPhone987	**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		

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 ☐ NJ PIP ☐ NYNF ☐ WC ☐ Legal Funding ☐ Self-Pay

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

Today's Date: txt_date	Previous Admission: Yes ☐ No ☐	
Patient's Name: txt_name|EmpName	Patient's Social Security # txt_ssn|SSN	
Patient's Gender: txt_sex|Sex	Patient's Date of Birth: txt_dob|DOB	
Patient's Home Address: txt_address|Address1		
City: txt_city|City	State: txt_state|State Zip Code: txt_zip|Zip	
Home Phone # txt_Phone2|Phone2	Work Phone # txt_Phone2|Phone2	Cell Phone # txt_mob|Phone2
Notify In Case of Emergency: Text14	Phone # Text15	Relationship: Text16
Primary Insurance: txt_InsCo|InsCo	Claims Address: Text18	
Insurance Co. Phone #: txt_InsPhone|InsPhone	Adjuster: txtAdjuster|Adjuster	
Policy ID # txt_policy_no|policy_no	Claim # txt_ClaimNumber|ClaimNumber	DOA/DOL: txt_doa|DOA
Secondary Insurance: Text24	Claims Address: Text31	
Insurance Co. Phone #: Text25	Adjuster: Text30	
Policy ID # Text26	Claim # Text29	DOA/DOL: Text32
Attorney's Name: txt_attorney|Attorney	Attorney's Phone #: txt_attorneyPhno|AttorneyPhno	

NB ALL PRIVATE INSURANCE/WORKERS' COMP/PIP CASES MUST HAVE PRIOR AUTHORIZATION FOR APPROVED TREATMENT

Admitting Diagnosis: M24.811

Text34

Proposed Procedure: Right Shoulder Arthroscopy - 29821, 29823, 29825

Text36

Text37

Referring Physician: Text38	Referring Clinic: Text39	Phone #: Text47
Admitting Surgeon: Dr. Anjani Sinha	Contact Person at Clinic: Eric - 718-886-2011	
Proposed Surgery Date: txtproc_code_date	Proposed Time of Surgery: Text46	
Anesthesia Type: Text42	Estimated Surgery Duration: Text48	
Surgeon Requires Assistant: Text43	Specific Supplies and/or Equipment: Text49	

Patient Needs Transportation: Yes ☒ No ☐

Note Pick Up Address if Different from Home (Above):

Text44

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: