NORTH QUEENS SURGICAL CENTER 45-64 FRANCIS LEWIS BLVD BAYSIDE NY 11361
Fax 929-258-7722
Email: Rbinder@northqsc.com

Physician:_____ Today's Date:_____

**PATIENT INFORMATION: (Please provide 2 phone numbers)**

LAST NAME:_____FIRST NAME_____

ADDRESS:_____

HOME #:_____ WORK #:_____ CELL #:_____

GENDER: SSN:_____ DOB: _____

HEIGHT _____ WEIGHT _____ BMI _____ PACEMAKER__ DIALYSIS __ PT SENT FOR CLEARANCE: CARDIAC__ PULMONARY__ RENAL __

** PLEASE MAKE SURE TO SEND ALL CLEARANCES TO 347-502-7350 ASAP TO ENSURE PATIENTS ARE PROPERLY CLEARED FOR SURGERY

Email address:_____

---- FOR NQSC USE ----
Reviewed by: _____
Date: _____
PT called _____ Date: _____
Assessment Completed: _____

**PROCEDURE INFORMATION**:

DATE OF SURGERY: _____ TIME: _____ LENGTH: _____

PROCEDURE CPT CODE(S): _____

PROCEDURE DESCRIPTION (as will be shown on consent): _____

_____

DIAGNOSIS CODE(S): _____ _____ _____ _____ _____ _____

DIAGNOSIS:_____

ANESTHESIA: General / MAC / ISB / Bier Block / Local ASSISTANT: Y / N LATEX ALLERGY: Y / N

SPECIAL REQUESTS (Implant / Equipment / Navigation / Medication): _____

_____

HIPAA CONSENT TO LEAVE VOICE MESSAGE ON PATIENT VOICEMAIL: ☐ YES ☐ NO

RELIGIOUS OR CULTURAL NEEDS: _____

**INSURANCE INFORMATION: Commercial, Medicare, Medicaid (MUST ATTACH COPY OF INSURANCE CARD)**

(Please circle which applies) WORKERS COMP NO FAULT HOW DID INJURY OCCUR: _____

NAME OF INSURANCE CARRIER:_____

PATIENT ID OR CLAIM #: _____ DATE OF ACCIDENT/INJURY:_____

WCB #:_____

CLAIM ADJUSTER NAME/NUMBER:_____

NAME OF ATTORNEY/ NUMBER : _____

INSURANCE APPROVAL OR AUTHORIZATION #: _____

** PLEASE ENSURE ALL PATIENTS (EXCEPT THOSE NOT RECEIVING ANY ANESTHESIA) HAVE AN ADULT ESCORT TO ACCOMPANY THEM HOME. CAR SERVICE DRIVERS ARE NOT CONSIDERED ESCORTS. **

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** | | | |