# Surgicore Surgical Center, LLC

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## 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: | Previous Admission: Yes ☐ No ☐ | |
| Patient's Name: | Patient's Social Security # | |
| Patient's Gender: M ☐ F ☐ | 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: | |
| Proposed Procedure: | |
| CPT Codes: | |

| | | |
|---|---|---|
| Referring Physician: | Referring Clinic: | Phone #: |
| Admitting Surgeon: | Contact Person at Clinic: | |
| Proposed Surgery Date: | Proposed Time of Surgery: | |
| Anesthesia Type: | Estimated Surgery Duration: | |
| Surgeon Requires Assistant: | Specific Supplies and/or Equipment: | |
| Patient Needs Transportation: Yes ☐ No ☐ | | |
| 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

Medical Staff's Signature: Patient's Signature: