Orthopaedic and Spine Institute of NJ

30 W. Century Road, Paramus NJ 07652

Tel.: 201-986-6770

Office Fax: 201-986-1010

ALL SECTIONS AND FIELDS MUST BE COMPLETED OR PATIENT WILL NOT BE SCHEDULED

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:	Patient's Date of Birth: / /	
Patient's Home Address:		
City:	State: Zip Code:	
Home Phone #	Work Phone #	Cell Phone #
Employer Name:	Employer Phone #	
Employer Address:		Employer Information is required for all work comp patients
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 ☐	**If transportation is needed,please do not advise patient of scheduled time. OSI will contact the patient with a proposed pickup time.**	
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 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 #		**WCB Group**	

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			