PAIN MANAGEMENT SURGICAL BOOKING FORM

Please fax all bookings with a current HIPAA, relevant notes & diagnostic testing to 201-537-6894 or email to bookings@lynxmm.com. Thank you!

PATIENT INFORMATION

Name:	DOB:	Age:		SSN:
Street Address:		City:	State:	Zip:
Home #:	Cell #:	E-Mail:	Language:	
Emergency Contact (Name & Relationship):			Phone #:	
Primary Physician Name:			Phone #:	

INSURANCE INFORMATION (Insurance card must accompany scheduling form (front & back))

Primary Ins Name:		Phone:	Policy #:
Subscriber Name:	DOB:	Relationship to Pt: ☐Self ☐Spouse ☐Parent ☐Other: _____	
Worker's Comp: Yes ☐ No ☐ ***PLEASE ATTACH*** No Fault: Yes ☐ No ☐ ***AUTH LETTER***	WCB#:	Case Claim #:	Phone #:
Is This A Lien: Yes ☐ No ☐ ***PLEASE ATTACH SIGNED LIEN***	Attorney Name:		Phone #:
Adjuster:	Auth #:	Date of Auth:	DOA/DOI:

SURGICAL PROCEDURE INFORMATION

Surgeon:	Assisting Surgeon:	Date Request #1: _____ #2: _____		
☐ ESI: Level: _____ Side: _____	☐ Cervical (62310) ☐ Thoracic (62310) ☐ Lumbar (62311) ☐ Caudal (62311)	☐ MBB ☐ Facet Level: _____ Side: _____	☐ Cervical(64490) ☐ Thoracic (64490) ☐ Lumbar (64493)	☐ Diagnostic ☐ Confirmatory
☐ TFESI: Level: _____ Side: _____	☐ Cervical (64479) ☐ Thoracic (64479) ☐ Lumbar (64483)	☐ RF: Level: _____ Side: _____	☐ Cervical (64633) ☐ Thoracic (64633) ☐ Lumbar (64493) ☐ Sacroiliac (64635) ☐ Other: _____	
☐ Discogram: Level: _____ Side: _____	☐ Cervical (62291) ☐ Thoracic (62291) ☐ Lumbar (62290)	☐ Discectomy Level: _____ Side: _____	☐ Cervical (63020) ☐ Thoracic (63020) ☐ Lumbar (63030)	
☐ SCS Trial ☐ SCS Perm Level: _____ Side: _____	☐ Cervical (62291) ☐ Lumbar (62290)	☐ Sympathetic Nerve Block Level: _____ Side: _____	☐ Stellate Ganglion Block (64510) ☐ Lumbar (64520)	
☐ TPI (20552 / 20553) Location(s):			☐ Sacroiliac Joint Injection (27069)	
☐ BMAC (0263T) Location(s):			Side:	

☐ Other: _____

_____

DIAGNOSIS

☐ Cervical Pain (M54.2) ☐ Mid Back Pain (M54.6) ☐ Radiculopathy (☐Cervical(M54.12) ☐Lumbar(M54.16) ☐Thoracic(M54.14)
☐ Low Back Pain (M54.5) ☐ Sciatica (M54.3) ☐ Spondylolysis (☐Cervical(M43.02) ☐Lumbar(M43.06) ☐Thoracic(M43.04)
☐ Herniated NP (M51.9) ☐ CRPS (G90.50) ☐ Facet Syndrome (M54.08) ☐ Other:

_____

SPECIAL REQUESTS

Equipment/Vendor:	Supplies:
Instrumentation:	Other:

PREOPERATIVE MEDICAL CLEARANCE

SCS Trial/Perm & Discectomy Patients require: H&P, EKG, Chest X-Ray, Blood Work (CBC w/ iff, CMP, PT/PTT) & Clean Catch UA
Clearing Physician/Clinic: _____ Phone: _____

SURGICAL SCHEDULER'S INFORMATION

Name:		Office/Clinic:
Phone:	E-Mail:	Booked By:

Surgeon Signature: _____ Date: _____ Reviewed By: _____

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			