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:** _____

Email address:_____

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: _____

_____

HIPAA CONSENT TO LEAVE VOICE MESSAGE ON PATIENT VOICEMAIL: [ ] **YES** [ ] **NO**

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

(Please circle which applies) **WORKERS COMP** **NO FAULT**

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 #: _____

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			