HACKENSACK SPECIALTY ASC
321 Essex St, Hackensack, NJ 07601
Phone: 201-549-9998 Ext. 1279 Fax: 646-585-4468
Email: verification@starssi.com

Surgical Booking Form

Patient Information

LAST	FIRST	MI	M F	DOB	AGE

STREET ADDRESS			SOCIAL SECURITY #

CITY	STATE	ZIP	EMERGENCY CONTACT

HOME #	WORK #	CELL #	EMERGENCY #

Surgical Procedure Information

SURGEON		ASSISTING SURGEON	

REQUEST DATE #1	TIME	REQUEST DATE #2	TIME	LENGTH OF CASE

PRIMARY PROCEDURE NAME	☐ LEFT ☐ RIGHT	CPT CODE #1	CPT CODE #2	CPT CODE #3	CPT CODE #4

SURGICAL DIAGNOSIS NAME	☐ LEFT ☐ RIGHT	ICD-9 CODE #1	ICD-9 CODE #2	ICD-9 CODE #3	ICD-9 CODE #4

Pre-Operative Medical Clearance

DOES THE PATIENT REQUIRE PRE-OP MEDICAL CLEARANCE? ☐ YES ☐ NO	IF YES, NAME OF CLEARING PHYSICIAN AND PHONE #:	
DOES THE PATIENT REQUIRE AN EKG? ☐ YES ☐ NO	PATIENT HEIGHT	PATIENT WEIGHT

Special Requests

EQUIPMENT	SUPPLIES
INSTRUMENTATION	OTHER

Insurance Information

IS THIS WORKMAN'S COMP? ☐ YES ☐ NO IS THIS NO FAULT? ☐ YES ☐ NO IS THIS PRIVATE HEALTH INS? ☐ YES ☐ NO	**PLEASE ATTACH AUTHORIZATION LETTER**	CASE CLAIM #	DATE OF INJURY
IS THIS A LIEN? ☐ YES ☐ NO **PLEASE ATTACH SIGNED LIEN**	ATTORNEY NAME		ATTORNEY PHONE #

PRIMARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB
POLICY #	RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER		
SECONDARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB
POLICY #	RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER		
EMPLOYER NAME	EMPLOYER ADDRESS		EMPLOYER PHONE #

Insurance Pre-Certification Authorization

INSURANCE COMPANY PHONE #	INSURANCE CO. REPRESENTATIVE	AUTH #	DATE OF AUTH.

Surgeon's Scheduler's Information

NAME	PHONE #	FAX #

Treating Physical Therapy Office

NAME	PHONE #	ADDRESS

Transportation:
☐ YES ☐ NO