

ASC of Rockaway

Phone: 718-819-5448 Fax: 718 945-8792

SURGICAL BOOKING FORM

PATIENT INFORMATION

LAST NAME		FIRST NAME		MI	AGE	M	F	DOB
STREET					SSN			
CITY	STATE		ZIP		EMERGENCY CONTACT			
TELEPHONE NUMBERS (PLEASE PROVIDE ALL)								
HOME		WORK		CELL		EMERGENCY		

SURGICAL PROCEDURE INFORMATION

SURGEON				ASSISTING SURGEON			
REQUEST DATE #1	TIME	REQUEST DATE #2	TIME	LENGTH OF CASE		ANESTHESIA TYPE	GENERAL <input type="checkbox"/> MAC <input type="checkbox"/> REGIONAL <input type="checkbox"/> LOCAL <input type="checkbox"/>
PRIMARY PROCEDURE NAME	LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/>	CPT CODE 1	CPT CODE 2	CPT CODE 3	CPT CODE 4	CPT CODE 5	CPT CODE 6
SURGICAL DIAGNOSIS NAME	LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/>	ICD-10 CODE 1	ICD-10 CODE 2	ICD-10 CODE 3	ICD-10 CODE 4	ICD-10 CODE 5	ICD-10 CODE 6

PREOPERATIVE MEDICAL CLEARANCE

DOES THE PATIENT REQUIRE PRE-OP MEDICAL CLEARANCE?	YES <input type="checkbox"/> NO <input type="checkbox"/>	IF YES, NAME OF CLEARING PHYSICIAN AND TELEPHONE NUMBER
DOES THE PATIENT REQUIRE AN EKG?	YES <input type="checkbox"/> NO <input type="checkbox"/>	PATIENT HEIGHT WEIGHT

SPECIAL REQUESTS

EQUIPMENT	SUPPLIES
INSTRUMENTATION	OTHER

INSURANCE INFORMATION

PRIMARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB
POLICY NUMBER	RELATIONSHIP TO PATIENT SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER <input type="checkbox"/>		
SECONDARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB
POLICY NUMBER	RELATIONSHIP TO PATIENT SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER <input type="checkbox"/>		
IS THIS WORKERS COMP? YES <input type="checkbox"/> NO <input type="checkbox"/> IS THIS NO FAULT? YES <input type="checkbox"/> NO <input type="checkbox"/>	CASE CLAIM NUMBER	DATE OF INJURY	
EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER	
IS THIS A LIEN? YES <input type="checkbox"/> NO <input type="checkbox"/> PLEASE ATTACH SIGNED LIEN	ATTORNEY NAME	ATTORNEY PHONE	

INSURANCE PRECERTIFICATION AUTHORIZATION

INSURANCE CO. PHONE	INSURANCE CO. REPRESENTATIVE	AUTHORIZATION NUMBER	DATE OF AUTHORIZATION
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SURGEON'S SCHEDULER'S INFORMATION

NAME	PHONE NUMBER
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Patient Information

Personal Information			
First Name	EMILY	Middle Name	-
Last Name	EDWARDS	D.O.B	01/24/2003
Gender	Female	Address	423 SOUTH FULLTON AVE APT3
City	MOUNT VERNON	State	NEW YORK
Cell Phone #	347-206-6391	Home Phone	718-881-5845
Work	-	Zip	10553
Email	-	Extn.	-
Attorney	DOMINICK LAVELLE	Case Type	No-Fault
Attorney Address	100 HERRICKS ROAD SUITE 201	Attorney Phone	800-745-4878
Case Status	OPEN	SSN	-

Insurance Information			
Policy Holder	-	Name	LIBERTY MUTUAL INS.
Address	P.O. Box# 1052	City	Montgomeryville
State	PENNSYLVANIA	Zip	18936-1052
Phone	800 245-1700	Fax	-
Contact Person	-	Claim File #	034381648
Policy #	AOS228001979405	WCB Group	

Accident Information			
Accident Date	09/14/2016	Plate Number	-
Report Number	-	Address	-
City	-	State	-
Hospital Name	-	Hospital Address	-
Date of Admission	-	Additional Patient	-
Describe Injury	-	Patient Type	Passenger

Employer Information			
Name	-	Address	-
City	-	State	-
Zip	-	Phone	-
Date of First Treatment	-	Chart #	-

Adjuster Information			
Name	-	Phone	-
Extension	-	Fax	-
Email	-		