NEW YORK CENTER FOR SPECIALTY SURGERY

PATIENT SCHEDULING SHEET

Fill out and fax to scheduler with any Physician's "Pre-Surgical Orders" to:
Scheduling Fax: 347-599-2633
Scheduling Phone: 347-599-2100

PATIENT INFORMATION

Date of Procedure:	Mon Tues Wed Thurs Fri Sat	Scheduled Time: AM PM	Procedure Length:
Patient's Name: (Last) (First) (MI)			Surgeon:
Address:			Assistant:

City:	State:	Zip:	Previous Patient? Yes No	23 HR Stay? Yes No
Social Security Number:		Date of Birth:	Age:	Sex:

Home Phone:	Cell Phone:	Anesthesia Type: General MAC Local Block Choice Conscious Sedation
Best number to contact yo Home Cell	May we leave a message? Home: Yes No Cell: Yes No	Emergency Contact: Phone: Relation:
Pre-op DX / ICD 9 Code:		
Procedure(s)/**CPT Codes**:		
Special Equipment Needs:		

INSURANCE INFORMATION

Responsible Party Name and Address (if different than above):					
Relation to Responsible Party: Self Child Spouse Other		Responsible Party SS#:	Responsible Party Employer:	Responsible Party Phone:	
Primary Insurance Carrier / Name of Insured			**Secondary** Insurance Carrier / Name of Insured:		
Insurance Billing Address and Phone			Secondary Billing Address and Phone:		
ID / SS#:	Group #:	Authorization #:	ID / SS#:	Group #:	Authorization #:
Insured's Employer and Phone #:			Insured's Employer and Phone #:		

Worker's Comp Info:	D.O.I.:	Claim #:	Adjustor:

PRE-ADMISSION PHYSICIAN ORDERS

Testing: o H & H o FBS if diabetic o Urine Preg o EKG	H&P Dictated: o No o Yes
For Local or Conscious Sedation: o Start IV of Lactated Ringers o No IV	Date:
	Job #:

Date: Time: 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			