ALLCITY FAMILY HEALTHCARE SURGERY CENTER

PATIENT SCHEDULING SHEET

Fill out and fax to scheduler with any Physician's "Pre-Surgical Orders" to:

Scheduling Fax: (718) 332-4472

Scheduling Phone Number:(718) 332-4409
PATIENT INFORMATION

Date of Procedure:	Mon Tues We	d Thurs Fri Sat	Sched	duled Time:	AM PM	Proce	dure Length:
Patient's Name: (Last	c)	(First)		(MI)		Surge	on:
Address:						Assist	ant:
City:			State:	Zip:	Previous AFHC par Yes No		
Social Security Number:		Date of Birth:		Age:	Sex:	1	
Home Phone:	Cell Phone:			hesia Type: neral MAC	Local Block	Choice	Conscious Sedation
Best number to contact you: Home Cell	May we leave a mes Home: Yes	sage? No Cell:	Υe	es No	Emergency Contact:		
Pre-op DX / ICD 10					Phone:	Right	Relation: Left Bilateral
Procedure(s)/CPT C	ode(s):						
Special Equipment Needs	:						
		INSUR <i>i</i>	NCF	INFORMAT	ION		
Responsible Party Name	and Address (if differe						
Relation to Responsible P	arty: Spouse Othe		ber's Birt	h Date Respo	onsible Party Employer:	Respo	onsible Party Phone:
Primary Insurance Carrier / Name of Insured							onsible i arty i none.
Insurance Billing Address				Seco	ndary Insurance Carrier /	Name of Insu	•
-	and Phone				ndary Insurance Carrier /		•
ID / SS#:	and Phone Group #:	Authoriz	zation #:		ndary Billing Address and		red:
Insured's Employer and P	Group #: hone #:		zation #:	Secor ID/S	ndary Billing Address and	Phone: Group #:	red: #: Authorization #:
	Group #:	:	Claim	Secon ID / S Insure	ndary Billing Address and S#: ed's Employer and Phone	Phone:	red: #: Authorization #:
Insured's Employer and P NF/Worker's Comp Info:	Group #: hone #:	PRE-ADMISS	Claim SION F	Secon ID / S Insure	ndary Billing Address and S#: ed's Employer and Phone	Phone: Group #:	red: #: Authorization #:
Insured's Employer and P	Group #: hone #:	PRE-ADMISS	Claim	Secon ID / S Insure	ndary Billing Address and S#: ed's Employer and Phone	Phone: Group #:	o #: Authorization #:

Printed By: claudiawp Printed on: 10/18/2017

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	-		

Source : https://www.gogreenbills.com