

Dynamic Surgery Center, LLC

321 Essex Street • Hackensack, NJ 07601

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SURGICAL BOOKING FORM

Patient Information						
LAST	FIRST	MI	Gender	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	<input type="checkbox"/> LEFT	<input type="checkbox"/> RIGHT	CPT CODE #1	CPT CODE #2	CPT CODE #3	CPT CODE #4
SURGICAL DIAGNOSIS NAME	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?		<input type="checkbox"/> NO	<input type="checkbox"/> YES	IF YES, NAME OF CLEARING PHYSICIAN AND PHONE #:		
DOES THE PATIENT REQUIRE AN EKG?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	PATIENT HEIGHT	PATIENT WEIGHT	
Special Requests						
EQUIPMENT		SUPPLIES				
INSTRUMENTATION		OTHER				
Insurance Information and Attorney Information						
IS THIS WORKMAN'S COMP?	PLEASE ATTACH		CASE CLAIM #	DATE OF INJURY		
IS THIS NO FAULT?	AUTHORIZATION LETTER					
IS THIS PRIVATE HEALTH INS?						
IS THIS A LIEN ?	ATTORNEY /LAW FIRM NAME			ATTORNEY PHONE #		
PLEASE ATTACH SIGNED LIEN						
PRIMARY INSURANCE	SUBSCRIBER NAME		SUBSCRIBER SSN		SUBSCRIBER DOB	
POLICY #	RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER					
SECONDARY INSURANCE	SUBSCRIBER NAME		SUBSCRIBER SSN		SUBSCRIBER DOB	
POLICY #	RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> 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 #		E-mail	
Treating Physical Therapy Office						
NAME	PHONE #		ADDRESS			
Transportation: <input type="checkbox"/> YES <input type="checkbox"/> NO						

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	-		