HACKENSACK SPECIALTYASC
321 Essex St, Hackensack, NJ 07601
Phone: 201-549-9998 Ext. 1274 or 1275 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

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			