Rockland and Bergen Surgery Center, LLC

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Patient Booking Form

☐ Medicare/Medicaid ☐ Private/Commercial ☐ NJ PIP ☐ NYNF ☐ WC ☐ Legal Funding ☐ Self-Pay

****MUST FAX BACK WITH LEGIBLE COPY OF PATIENT'S INSURANCE CARD: FRONT & BACK ****

Today's Date:	Previous Admission:	Yes ☐	No ☐
Patient's Name:		Patient's Social Security #	
Patient's Gender:		Patient's Date of Birth:	
Patient's Home Address:			
City:	State:	Zip Code:	
Home Phone #	Work Phone #	Cell Phone #	
Notify In Case of Emergency:	Phone #	Relationship:	
Primary Insurance:		Claims Address:	
Insurance Co. Phone #:		Adjuster:	
Policy ID #	Claim #	DOA/DOL:	
Secondary Insurance:		Claims Address:	
Insurance Co. Phone #:		Adjuster:	
Policy ID #	Claim #	DOA/DOL:	
Attorney's Name:		Attorney's Phone #:	

NB ALL PRIVATE INSURANCE/WORKERS' COMP/PIP CASES MUST HAVE PRIOR AUTHORIZATION FOR APPROVED TREATMENT

CPT:	
ICD10:	
Admitting Diagnosis:	
Proposed Procedure:	
Referring Physician:	Referring Clinic Phone #:
Admitting Surgeon:	Contact Person at Clinic:
Proposed Surgery Date:	Proposed Time of Surgery:
Anesthesia Type:	Estimated Surgery Duration:
Surgeon Requires Assistant:	Specific Supplies and/or Equipment:

Patient Needs Transportation: Yes☐ No☐

Note Pick Up Address if Different from Home (Above):

Affirmation By Medical Staff that He/She has Explained Proposed Procedure to the Patient to the Fullest Extent Possible By State Law

Medical Staff's Signature:	Patient's

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			