ESASC **SCHEDULING and PHYSICIAN ORDER FORM**

PATIENT LAST NAME: txt_lname|LastName **FIRST**: txt_fname|FirstName MI: _____

PATIENT ADDRESS: txt_address|Address1 County _____

CITY: txt_City|City **STATE:** txt_ **ZIP:** txt_zip|Z **HOME TEL**: txt_Phone2|Phone CELL: txt_mob|MiddleNar

DOB: txt_dob|DOB AGE: txt_age|AGI **SEX:** txt_sex|S **S.S#**: txt_ssn|SSN **MARITAL STATUS**: S M W D

Race _____ **Ethnicity**_____ **Height**: _____ **Weight**: _____ EMAIL ADDRESS txt_email|EmailAddress

Insurance Information – PLEASE FAX INSURANCE CARD (Front and Back)

INSURANCE COMPANY NAME: txt_InsCo|InsCo TEL: ( ): txt_mob|MiddleName

INSURED NAME: txt_name|patientfullname POLICY/GROUP #: txt_policy_no|policy_no

ID#: _____ **AUTHORIZATION #:**_____

DATE OF INJURY: _____ Auto Worker's Comp Other _____

PATIENT RELATIONSHIP TO INSURED: Self Spouse Other_____

SECONDARY INSURANCE? NO YES _____ _____ txt_Phone|Phone

Company Name ID# Telephone

SURGEON: _____
PRINT

BMI: ____ **CLEARANCE REQD: Y**__ **N**___

PATIENT DIABETIC? _____**YES** _____**NO**

DIAGNOSIS:
ICD 10 _____ **Desc:** _____
ICD 10 _____ **Desc.** _____

PROCEDURE(S):
CPT CODE _____ **DESCRIPTION** _____
CPT CODE _____ **DESCRIPTION** _____
CPT CODE_____ **DESCRIPTION**_____

DOES THE PATIENT SUFFER FROM SLEEP APNEA: **YES** **NO**

DOES THE PATIENT USE A : **PACEMAKER** **AICD**

SPECIAL EQUIPMENT:	
IMPLANT/DEVICE:	
TYPE OF ANESTHESIA	**MAC** ___ **GENERAL** ___ **OCULAR BLOCK** ____ **REGIONAL BLOCK**____ **LOCAL**____
REQUESTED DATE/TIME: **LENGTH OF PROCEDURE:**	**DATE:** txt_date|ToDay **TIME:** _____ **LENGTH OF PROC.** _____

PHYSICIAN ORDERS: (*Must be authenticated by physician prior to submission*)

PROCEDURE CONSENT PER BOOKING SHEET:

_____

No abbreviations and specify laterality.

_____

ANTIBIOTIC: _____ _____ _____
Dose Route

OTHER: _____ _____ _____
Dose Route

PHYSICIAN SIGNATURE: _____ DATE: _____ TIME_____

3170 Webster Ave. Bronx, New York 10467 Tel: 718-708-5777 Fax: 718-708-4963

Patient Information

Personal Information			
First Name	txt_fname|FirstName	**Middle Name**	
Last Name	txt_lname|LastName	**D.O.B**	txt_dob|DOB
Gender	txt_sex|Sex	**Address**	txt_address|Address1
City	txt_city|City	**State**	txt_state|State
Cell Phone #	txt_mob|MiddleName	**Home Phone**	txt_Phone2|Phone
Work	txt_work_phone|work_phone	**Zip**	txt_zip|Zip
Email	txt_eMail|EmailAddress	**Extn.**	
Attorney	txt_attorney|Attorney	**Case Type**	txt_casetype|WCBGroup
Attorney Address	txt_attorneyAdd|AttorneyAdd	**Attorney Phone**	txt_attorneyPhno|AttorneyPhno
Case Status		**SSN**	txt_ssn|SSN

Insurance Information			
Policy Holder	txt_name123|patientfullname	**Name**	txt_InsCo|InsCo
Address	txt_Insaddress987|InsAddress1	**City**	txt_Inscity|InsCity
State	txt_Insstate987|InsState	**Zip**	txt_Inszip|Inszip
Phone	txt_InsPhone987|InsPhone	**Fax**	
Contact Person		**Claim File #**	txt_ClaimNumber|ClaimNumber
Policy #	txt_policy_no|policy_no	**WCB Group**	txt_WCBGroup|WCBGroup

Accident Information			
Accident Date		**Plate Number**	
Report Number		**Address**	
City		**State**	
Hospital Name		**Hospital Address**	
Date of Admission	txt_doe12|LASTDOE	**Additional Patient**	
Describe Injury		**Patient Type**	

Employer Information			
Name	txt_EmpName|EmpName	**Address**	txt_EmpAddress|EmpAddress
City		**State**	
Zip		**Phone**	txt_EmpPhone|EmpPhone
Date of First Treatment		**Chart #**	

Adjuster Information			
Name	txtAdjuster|AdjUserName	**Phone**	txtAdjusterph|AdjPhone
Extension		**Fax**	
Email			