SURGICARE OF BROOKLYN

313 43rd St, Brooklyn, NY 11232
Phone: 201-549-9998 Ext. 1279 Fax: 646-585-4468
Email: verification@starssi.com

Patient Email: _____

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 NY 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