ESASC **SCHEDULING and PHYSICIAN ORDER FORM**

PATIENT LAST NAME: _____ **FIRST:** _____ MI: _____

PATIENT ADDRESS: _____ County _____

CITY: _____ **STATE:** ____ **ZIP:** _____ **HOME TEL:** _____ CELL: _____

DOB: _____ AGE: _____ **SEX:** **S.S#:** _____ **MARITAL STATUS:** S M W D

Race _____ **Ethnicity** _____ **Height:** _____ **Weight:** _____ EMAIL ADDRESS _____

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

INSURANCE COMPANY NAME: _____ TEL: ( ): _____

INSURED NAME: _____ POLICY/GROUP #: _____

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

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

PATIENT RELATIONSHIP TO INSURED: Self Spouse Other _____

SECONDARY INSURANCE? NO YES _____ _____ _____
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:** _____ **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		**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			