



92-12 165<sup>th</sup> St, Jamaica, NY 11433

Phone: 201-549-9998 Ext. 1279 Fax: 646-585-4468

Email: [verification@starssi.com](mailto:verification@starssi.com)

Patient Email: \_\_\_\_\_

### Surgical Booking Form

<b>Patient Information</b>					
LAST	FIRST	MI	<input type="checkbox"/> M <input type="checkbox"/> F	DOB	AGE
STREET ADDRESS			SOCIAL SECURITY #		
CITY	STATE	ZIP	EMERGENCY CONTACT		
HOME #	WORK #	CELL #	EMERGENCY #		
<b>Surgical Procedure Information</b>					
SURGEON		ASSISTING SURGEON			
REQUEST DATE #1	TIME	REQUEST DATE #2	TIME	LENGTH OF CASE	
PRIMARY PROCEDURE NAME	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	CPT CODE #1	CPT CODE #2	CPT CODE #3	CPT CODE #4
SURGICAL DIAGNOSIS NAME	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	ICD-9 CODE #1	ICD-9 CODE #2	ICD-9 CODE #3	ICD-9 CODE #4
<b>Pre-Operative Medical Clearance</b>					
DOES THE PATIENT REQUIRE PRE-OP MEDICAL CLEARANCE?		IF YES, NAME OF CLEARING PHYSICIAN AND PHONE #:			
<input type="checkbox"/> YES <input type="checkbox"/> NO					
DOES THE PATIENT REQUIRE AN EKG?		PATIENT HEIGHT	PATIENT WEIGHT		
<input type="checkbox"/> YES <input type="checkbox"/> NO					
<b>Special Requests</b>					
EQUIPMENT		SUPPLIES			
INSTRUMENTATION		OTHER			
<b>Insurance Information</b>					
IS THIS WORKMAN'S COMP?	<input type="checkbox"/> YES <input type="checkbox"/> NO	PLEASE ATTACH		CASE CLAIM #	DATE OF INJURY
IS THIS NY NO FAULT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	AUTHORIZATION LETTER			
IS THIS PRIVATE HEALTH INS?	<input type="checkbox"/> YES <input type="checkbox"/> NO				
IS THIS A LIEN?	<input type="checkbox"/> YES <input type="checkbox"/> NO	ATTORNEY NAME		ATTORNEY PHONE #	
PLEASE ATTACH SIGNED LIEN					
PRIMARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB		
POLICY #	RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER				
SECONDARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB		
POLICY #	RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER				
EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE #			
<b>Insurance Pre-Certification Authorization</b>					
INSURANCE COMPANY PHONE #	INSURANCE CO. REPRESENTATIVE	AUTH #	DATE OF AUTH.		
<b>Surgeon's Scheduler's Information</b>					
NAME	PHONE #	FAX #			
<b>Treating Physical Therapy Office</b>					
NAME	PHONE #	ADDRESS			
<b>Transportation:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO					

## Patient Information

Personal Information			
First Name	EMILY	Middle Name	-
Last Name	EDWARDS	D.O.B	01/24/2003
Gender	Female	Address	423 SOUTH FULLTON AVE APT3
City	MOUNT VERNON	State	NEW YORK
Cell Phone #	347-206-6391	Home Phone	718-881-5845
Work	-	Zip	10553
Email	-	Extn.	-
Attorney	DOMINICK LAVELLE	Case Type	No-Fault
Attorney Address	100 HERRICKS ROAD SUITE 201	Attorney Phone	800-745-4878
Case Status	OPEN	SSN	-

Insurance Information			
Policy Holder	-	Name	LIBERTY MUTUAL INS.
Address	P.O. Box# 1052	City	Montgomeryville
State	PENNSYLVANIA	Zip	18936-1052
Phone	800 245-1700	Fax	-
Contact Person	-	Claim File #	034381648
Policy #	AOS228001979405	WCB Group	

Accident Information			
Accident Date	09/14/2016	Plate Number	-
Report Number	-	Address	-
City	-	State	-
Hospital Name	-	Hospital Address	-
Date of Admission	-	Additional Patient	-
Describe Injury	-	Patient Type	Passenger

Employer Information			
Name	-	Address	-
City	-	State	-
Zip	-	Phone	-
Date of First Treatment	-	Chart #	-

Adjuster Information			
Name	-	Phone	-
Extension	-	Fax	-
Email	-		