Health Plus Surgical Center, LLC
CitiMed Services
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Surgical Booking Form

Patient Information

LAST	FIRST	MI	Gender	DOB	AGE
txt_lname|LastName	txt_fname|FirstName	txt_mna	txt_sex|Sex	txt_dob|DOB	txt_age

STREET ADDRESS	SOCIAL SECURITY #
txt_address|Address1	txt_ssn|SSN

CITY	STATE	ZIP	EMERGENCY CONTACT
txt_city|City	txt_state|State	txt_zip|Zip	

HOME #	WORK #	CELL #	EMERGENCY #
	txt_work_phone|work_phone	txt_mob|Phone2	

Surgical Procedure Information

SURGEON Ketan D Vora, DO	ASSISTING SURGEON

REQUEST 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? / IS THIS NO FAULT? / IS THIS PRIVATE HEALTH INS?	PLEASE ATTACH AUTHORIZATION LETTER	CASE CLAIM #	DATE OF INJURY
		txt_ClaimNumber|ClaimNur	txt_doa|DOA

IS THIS A LIEN? / PLEASE ATTACH SIGNED LIEN	ATTORYNEY NAME	ATTORNEY PHONE #
	txt_attorney|Attorney	txt_attorneyPhno|AttorneyPhno

PRIMARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB
txt_InsCo|InsCo			

POLICY #	RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

SECONDARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB

POLICY #	RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER
txt_policy_no1|policy_no	

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE #
empname|EmpName	empad|EmpAddress	empph|EmpPhone

Insurance Pre-Certification Authorization

INSURANCE COMPANY PHONE #	INSURANCE CO. REPRESENTATIVE(Adjuster) AUTH #	DATE OF AUTH.
txt_InsPhone|InsPhone	txtAdjuster|AdjUserName txtAdjusterph|AdjPho	

Surgeon's Scheduler's Information

NAME	PHONE #	FAX #

Treating Physical Therapy Office

NAME	PHONE #	ADDRESS

Transportation:
☐ YES ☐ NO

Patient Information

Personal Information

First Name	txt_fname|FirstName	**Middle Name**	txt_mname|MiddleName
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|Phone2	**Home 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 #		**WCB Group**	txt_WCBGroup|WCBGroup

Accident Information

Accident Date	txt_doa|DOA	**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			