Surgi Core of Jersey City, LLC

Telephone: 201-795-0205
Fax: 201-795-0737

550 Newark Ave. Jersey City, NJ 07306

Patient Booking Form

☐ Medicare/Medicaid ☐ Private/Commercial ☐ NJ PIP ☐ NYNF ☐ WC ☐ Legal Funding ☐ Self-Pay

** MUST FAX BACK WITH LEGIBLE COPY OF PATIENT'S INSURANCE CARD: FRONT & BACK **

Today's Date: Previous Admission: Yes ☐ No ☐

Patient's Name: Patient's Social Security #

Patient's Gender: Patient's Date of Birth:

Patient's Home Address:

City: State: Zip Code:

Home Phone # Work Phone # Cell Phone #

Notify In Case of Emergency: Phone # Relationship:

Primary Insurance: Claims Address:

Insurance Co. Phone #: Adjuster:

Policy ID # Claim # DOA/DOL:

Secondary Insurance: Claims Address:

Insurance Co. Phone #: Adjuster:

Policy ID # Claim # DOA/DOL:

Attorney's Name: Attorney's Phone #:

NB ALL PRIVATE INSURANCE/WORKERS' COMP/PIP CASES MUST HAVE PRIOR AUTHORIZATION FOR APPROVED TREATMENT

Admitting Diagnosis:

Proposed Procedure:

Referring Physician: Referring Clinic: Phone #:

Admitting Surgeon: Contact Person at Clinic:

Proposed Surgery Date: Proposed Time of Surgery:

Anesthesia Type: Estimated Surgery Duration:

Surgeon Requires Assistant: Specific Supplies and/or Equipment:

Patient Needs Transportation: Yes ☐ No ☐

Note Pick Up Address if Different from Home (Above):

Affirmation By Medical Staff that He/She has Explained Proposed Procedure to the Patient to the Fullest Extent Possible By State Law

Medical Staff's Signature: Patient's Signature:

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			