New Horizon Surgical Center, LLC

680 Broadway, Suite 201, Paterson, NJ 07514

Main Tel.: (973) 782-4202
Office Fax: (973) 782-4206
Booking E-Fax: (973) 807-9382

Patient Booking Form

Today's Date:	Previous Admission: Yes ☐ No ☐
Patient's Name:	Patient's Date of Birth:
Patient's Gender:	Patient's Social Security #:

Medicare/Medicaid | Private/Commercial | NJ PIP | NY NF | WC | Legal Funding | Self-Pay

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

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

Admitting Diagnosis:

Proposed Procedure:

Specific Supplies and/or Equipment:

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:

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			