Dynamic Surgery Center, LLC
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SURGICAL BOOKING FORM

Patient Information

LAST	FIRST	MI	Gender	DOB	AGE
STREET ADDRESS				SOCIAL SECURITY #	
CITY	STATE	ZIP	EMERGENCY CONTACT		
HOME #	WORK #	CELL #	EMERGENCY #		

Surgical Procedure Information

SURGEON	ASSISTING SURGEON				
REQUEST DATE #1	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	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? ☐NO ☐YES	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 and Attorney Information

IS THIS WORKMAN'S COMP?	**PLEASE ATTACH**	CASE CLAIM #	DATE OF INJURY
IS THIS NO FAULT?	**AUTHORIZATION LETTER**		
IS THIS PRIVATE HEALTH INS?			
IS THIS A LIEN ?	**ATTORNEY /LAW F IRM NAME**		**ATTORNEY PHONE #**
PLEASE ATTACH SIGNED LIEN			

PRIMARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB
POLICY #	RELATIONSHIP TO PATIENT: ☐ SELF	☐ SPOUSE ☐ PARENT	☐ OTHER
SECONDARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB
POLICY #	RELATIONSHIP TO PATIENT ☐ SELF	☐SPOUSE ☐ PARENT	☐ OTHER
EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE #	

Insurance Pre-Certification Authorization

INSURANCE COMPANY PHONE #	INSURANCE CO. REPRESENTATIVE	AUTH #	DATE OF AUTH.

Surgeon's Scheduler's Information

NAME	PHONE #	FAX #	E-mail

Treating Physical Therapy Office

NAME	PHONE #	ADDRESS

Transportation:
☐YES ☐NO

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			