CITIMED SURGERY CENTER

92-12 165th St, Jamaica, NY 11433
Phone: 201-549-9998 Ext. 1279 Fax: 646-585-4468
Email: verification@starssi.com

Patient Email: txt_email|EmailAddress

Surgical Booking Form

Patient Information

LAST	FIRST	MI		DOB	AGE
txt_lname|LastName	txt_fname|FirstName	txt_mname	☐ M ☐ F	txt_dob|DOB	txt_age|AG

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_Phone2|work_phone		txt_mob|Phone2	

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	☐ 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?	☐ YES	☐ NO	**PLEASE ATTACH**	CASE CLAIM #	DATE OF INJURY
IS THIS NY NO FAULT?	☐ YES	☐ NO	**AUTHORIZATION LETTER**		
IS THIS PRIVATE HEALTH INS?	☐ YES	☐ NO		txt_ClaimNumber|Cla	txt_doa|DOA
IS THIS A LIEN? **PLEASE ATTACH SIGNED LIEN**	☐ YES	☐ NO	ATTORNEY NAME: txt_attorney|Attorney		ATTORNEY PHONE #: txt_attorneyPhno|AttorneyPh

PRIMARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB
txt_InsCo|InsCo	txt_name|patientfullnam	txt_ssn|SSN	txt_dob|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
txt_policy_no|policy_no	

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE #

Insurance Pre-Certification Authorization

INSURANCE COMPANY PHONE #	INSURANCE CO. REPRESENTATIVE	AUTH #	DATE OF AUTH.
txt_InsPhone|InsPhone			

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**	**txt_Phone2|work_phone**
Work		**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|Attorney**
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|ClaimNu**
Policy #	**txt_policy_no|policy_no**	**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			