

New Horizon Surgical Center, LLC

680 Broadway, Suite 201, Paterson, NJ 07514

Patient Booking Form

Main Tel.: (973) 782-4202

Office Fax: (973) 782-4206

Booking E-Fax: (973) 807-9382

| | | | |
|--|--|--|----------|
| Today's Date: | | Previous Admission: Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Patient's Name: | | Patient's Date of Birth: | |
| | | | |
| Patient's Gender: <input type="checkbox"/> M <input type="checkbox"/> F | | Patient's Social Security #: | |
| | | | |
| <input type="checkbox"/> Medicare/Medicaid <input type="checkbox"/> Private/Commercial <input type="checkbox"/> NJ PIP <input type="checkbox"/> NY NF <input type="checkbox"/> WC <input type="checkbox"/> Legal Funding <input type="checkbox"/> 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 | | | |
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| Admitting Diagnosis: | | | |
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| Proposed Procedure: | | | |
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| Specific Supplies and/or Equipment: | | | |
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| | | | |
| 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 <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 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: | |