Premier Surgery Center of Clifton
999 Clifton Ave,
Clifton, NJ 07013
Phone: (973) 354-2484

Premier SURGERY CENTER OF CLIFTON

Surgical Booking Form

Patient Information

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

STREET ADDRESS	SOCIAL SECURITY #
txt_address|Address1	txt_ssn|SSN

CITY	STATE	ZIP	EMERGENCY CONTACT
txt_city|City	txt_state|State	txt_zip|Zip	txt_mob|Phone2

HOME #	WORK #	CELL #	EMERGENCY #
txt_Phone2|Phone	txt_work_phone|work_	txt_mob|Phone2	

Surgical Procedure Information

SURGEON	ASSISTING SURGEON
Billy Ford, MD	

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?	IF YES, NAME OF CLEARING PHYSICIAN AND PHONE #:
☐ YES ☑ NO	

DOES THE PATIENT REQUIRE AN EKG?	PATIENT HEIGHT	PATIENT WEIGHT
☐ YES ☑ NO		

Special Requests

EQUIPMENT	SUPPLIES

INSTRUMENTATION	OTHER

Insurance Information

IS THIS WORKMAN'S COMP? ☐YES ☐ NO	**PLEASE ATTACH**	CASE CLAIM #	DATE OF INJURY
IS THIS NO FAULT? ☐YES ☐ NO	**AUTHORIZATION LETTER**	txt_ClaimNumber|Clai	txt_doa|DOA
IS THIS PRIVATE HEALTH INS? ☐YES ☐ NO			

IS THIS A LIEN? ☐ YES ☐ NO **PLEASE ATTACH SIGNED LIEN**	ATTORNEY NAME	ATTORNEY PHONE #
	txt_attorney|Attorney	txt_attorneyPhno|AttorneyPhno

PRIMARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB
txt_InsCo|InsCo			

POLICY #	RELATIONSHIP TO PATIENT
txt_policy_no|policy_no	☑ 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.
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	demo_fname|FirstName	**Middle Name**	demo_mname|MiddleName
Last Name	demo_lname|LastName	**D.O.B**	demo_dob|DOB
Gender	demo_sex|Sex	**Address**	demo_address|Address1
City	demo_city|City	**State**	demo_state|State
Cell Phone #	demo_mob|Phone2	**Home Phone**	demo_Phone2|Phone
Work	demo_work_phone|work_phone	**Zip**	demo_zip|Zip
Email	demo_eMail|EmailAddress	**Extn.**	
Attorney	demo_attorney|Attorney	**Case Type**	demo_casetype|Compensation
Attorney Address	demo_attorneyAdd|AttorneyAdd	**Attorney Phone**	demo_attorneyPhno|AttorneyPhno
Case Status		**SSN**	demo_ssn|SSN

Insurance Information

Policy Holder	demo_name123|patientfullname	**Name**	demo_InsCo|InsCo
Address	demo_Insaddress987|InsAddress1	**City**	demo_Inscity|InsCity
State	demo_Insstate987|InsState	**Zip**	demo_Inszip|Inszip
Phone	demo_InsPhone987|InsPhone	**Fax**	
Contact Person		**Claim File #**	demo_ClaimNumber|ClaimNumbe
Policy #	demo_policy_no|policy_no		

Accident Information

Accident Date	demo_doa|DOA	**Plate Number**	
Report Number		**Address**	
City		**State**	
Hospital Name		**Hospital Address**	
Date of Admission	demo_doe12|LASTDOE	**Additional Patient**	
Describe Injury		**Patient Type**	

Employer Information

Name	demo_empname|EmpName	**Address**	demo_empaddress|EmpAddress
City		**State**	
Zip		**Phone**	demo_empphone|EmpPhone
Date of First Treatment		**Chart #**	

Adjuster Information

Name	demoAdjuster|AdjUserName	**Phone**	demoAdjusterph|AdjPhone
Extension		**Fax**	
Email			