New Horizon Surgical Center, LLC

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Booking E-Fax: (973) 807-9382
Booking Email: bookings@newhorizonasc.com

Patient Booking Form

Today's Date: txt_date|ToDay **Previous Admission:** YES ☐ NO ☐

Patient's Name: Patients Name|patientfullname **Patient's Date of Birth:** Patients Date of Birth|DOB

Patient's Gender: ☐ M ☐ F ☐ Other **Please Specify:** _____ **Patient Goes By Different Name:**

Patient's Contact Phone #: Patients Contact Phone|Phone2 **(Cell / Work / Other)** **Patient's Contact Phone #:** Cell Work Other Patients Contact Phone fk|work_phone **(Cell / Work / Other)**

Patient's Preferred Language: ☐ ENGLISH ☐ SPANISH ☐ OTHER : _____ **Needs Interpreter:** YES ☐ NO ☐

Patient Needs Transportation: YES ☑ NO ☐

Note Pick Up Address if Different from DEMO SHEET Provided:

☐ Medicare/Medicaid ☐ Private/Commercial OON ☐ NJ PIP ☐ NY NF ☐ WC ☐ LOP/LIEN ☐ Legal Funding ☐ Self-Pay

Attorney Name: Attorney Name|Attorney **Attorney Phone #:** Attorney Phone|AttorneyPh **DOA:** DOA|DOA

**** 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 & Codes:

Proposed Procedure & CPT Codes:

Specific Supplies and/or Equipment:

Referring Physician: Billy H Ford, MD **Contact Phone #:**

Admitting Surgeon: Billy H Ford, MD **Contact Person at Medical Office:**

Proposed Surgery Date: . . **Requested Time of Surgery:**

Anesthesia Type: **Estimated Duration of Surgery:**

Surgeon Requires Assistant:

Affirmation by Medical Staff that the Proposed Procedure has been explained to the Patient to the Fullest Extent Possible By State Law:

Medical Staff's Signature: **Patient's Signature:**

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			