Bergen County Surgery Center

Patient Information			
LAST: FIRST: M F			DATE OF BIRTH:
STREET ADDRESS:			
CITY: ZIP:			
HOME # WORK #			CELL #

Surgical Procedure Information	
SURGEON: GAMBURG	PROCEDURE:
PRIMARY PROCEDURE NAME CPT CODES:	
SURGICAL DIAGNOSIS NAME/ CODE:	

Special Requests	
EQUIPMENT	SUPPLIES
REP	

Insurance Information and Attorney Information

			INSURANCE NAME:	CASE CLAIM#	DATE OF INJURY:
IS THIS WORKMAN'S COMP?	☐ YES	☐ NO			
IS THIS NO FAULT?	☐ YES	☐ NO			
IS THIS PRIVATE HEALTH INS?	☐ YES	☐ NO			
IS THIS A LIEN ? ☐ YES ☐ NO			ATTORNEY /LAW FIRM NAME:		ATTORNEY PHONE #

Insurance Pre-Certification Authorization

AUTHORIZATION REQUIRED	AUTH #	DATE OF AUTH.
☐ YES ☐ NO		
Transportation: ☐ YES ☐ NO		
NOTES:		