Podiatric Surgical Booking Form

Gramercy Surgery Center, Inc
(212) 254-3570 Fax: (866) 567-3772

Surgeon:	Asst. Surgeon:	Location: ☐ Manhattan ☐ Queens

Date Requested:	Start Time:	OR Duration:	Anesthesia Type:

Patient Information

Last Name:	First Name:
Street Address:	City/State/Zip:
DOB:	Home Phone:
Cellular Phone:	Work Phone:
SSN:	☐ Male ☐ Female
Height:	Weight (lbs):
PCP Name	PCP Phone:

Insurance Information

Primary Insurance	Policy Number	Subscriber	DOB
Insurance Phone	Authorization		
Secondary Insurance	Policy Number	Subscriber	DOB

Primary Procedure Name: Please check all procedures being performed							
Excision of nail & nail matrix (11750)	L	R	B	Pulse Dye (17110)	L	R	B
Removal of Implant (deep) (20680)	L	R	B	Excision of neuroma (interdigital) (28080)	L	R	B
Excision of Cyst/Ganglion (28090)	L	R	B	Fasciotomy(28108)	L	R	B
Osteotomy, partial excision, 5th metatarsal head (28110)	L	R	B	Capsulotomy (28270)	L	R	B
Arthroplasty (correction of hammer toe) (28285)	L	R	B	Hallus rigidus correction with cheilectomy, debridement & capsular release of 1st MTP (28289)	L	R	B
Keller Bunionectomy (28292)	L	R	B	Austin Bunionectomy (28296)	L	R	B
Osteotomy (28299)	L	R	B	Well Osteotomy (28308)	L	R	B
Sesamoidectomy (first toe) (28315)	L	R	B	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation (28465)	L	R	B
Open treatment of metatarsal fracture, includes internal fixation (28485)	L	R	B	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation (28525)	L	R	B
Open treatment of tarsometatarsal joint dislocation, includes internal fixation (28615)	L	R	B	Arthrodesis (great toe) (28750)	L	R	B
Amputation of toe (28020)	L	R	B	Endoscopic Plantar Fasciotomy (29893)	L	R	B

Other Procedure Description: _____ **CPT Codes**: _____

Diagnosis (ICD-10): _____ **Mini C-Arm:** ☐ **Y** ☐ **N**

Antibiotics to be administered in Pre-Op: ☐ **Y** ☐ **N** _____

Supplies/Equipment

Implant: _____ **Size**: _____ **Vendor**: _____

Rep. Requested		Name of Rep:

Please fax a copy of the front and back of the patient's insurance card.

Person completing form _____ **Phone:** _____ **Date:** _____