ENT Surgical Booking Form

Gramercy Surgery Center, Inc
(212) 254-3570 Fax: (866) 249-5146

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**
PCP Name:	**PCP Phone:**
Email:	

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					
Septoplasty (30520)		Sphenoidectomy (31287-50)		Intranasal Synechia Repair (30560)	
Inferior Turbinate Reduction (30140-50)		Image Guidance (61782)		Cautery or Ablation Inf. Turb Mucosa(30801)	
Vestibular Stenosis (30465)		Concha Bullosa Resection (31240-50)		Balloon- Frontal (31296-50)	
Adenoidectomy (42831)		Nasal Sinus Surgery with Polypectomy (31237)		Balloon- Maxillary (31295-50)	
Maxillary Antrostomy (31267-50)		Fractured Nose & Septum (21335)		Balloon-Sphenoid (31297-50)	
Anterior Ethmoidectomy (31254-50)		Auricular Cartilage Graft (21235)		Uvulectomy (42160)	
Total Ethmoidectomy (31255-50)		Nasal Septum Cartilage Graft (20912)		Elongated Uvula (42140)	
Frontal Sinusotomies (31276-50)		Repair Septal Perforation (30630)		Nasal Sinus Endo w/Maxillary (31256)	

Other Procedures: _____ **CPT Codes**: _____

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

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

Please check supplies needed:					
Balloons (Acclarent) Frontal		Balloons (Acclarent) Maxillary		Balloons (Acclarent) Sphenoid	
Balloons (Nuvent/Medtronic) Frontal		Balloons (Nuvent/Medtronic) Maxillary		Balloons (Nuvent/Medtronic) Sphenoid	
Medtronic Fusion Set		Medtronic Non-Fusion Blade		Propel Stent (Small)	
Brain Lab		Olympus Diego Elite		Propel Stent (Large)	
Smith&Nephew Septal Stapler		Smith&Nephew Coblator Wand		Olympus Celon	
Nasal Splints					

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:** _____