



BOOKING: 646-350-3338
FAX: 866-249-5146

SURGICAL BOOKING FORM

LOCATION(S): MANHATTAN QUEENS

SURGEON(S): _____

DATE OF SURGERY: _____ **TIME:** _____ **ESTIMATED LENGTH:** _____

PATIENT'S NAME: _____ Male Female

EMAIL: _____

RACE: _____ **ETHNICITY:** _____

DATE OF BIRTH: _____ **(H) PHONE:** _____

ADDRESS: _____ **(W) PHONE:** _____

_____ **(C) PHONE:** _____

_____ **SS#:** _____

PRIMARY CARE PHYSICIAN'S (PCP) CONTACT INFORMATION

PCP'S NAME: _____ **TEL:** _____

INS. CARRIER: _____

INS. CARRIER PHONE: _____

SUBSCRIBER'S NAME: _____ **DOB:** _____

INS. ID #: _____ **PRECERT #:** _____

SECONDARY INS. CARRIER: _____

SECONDARY INS. CARRIER PHONE: _____

SUBSCRIBER'S NAME: _____ **DOB:** _____

INS. ID #: _____

PROCEDURE DESCRIPTION: _____

CPT CODE: _____

DIAGNOSIS W/ CODE: _____

ANESTHESIA TYPE: (PLEASE CHOOSE ONE) General MAC Epidural Local

ANTIBIOTICS TO BE ADMINISTERED IN PRE-OP: No Yes _____

WILL A PHYSICIAN'S ASSISTANT BE NEEDED AS FIRST ASSIST?: (Please Choose one) Yes No

SUPPLY/EQUIPMENT REQUISITION: (PLEASE INDICATE SPECIAL REQUEST(S)) **C-Arm Required?** No Yes

POSITIONING OF PATIENT:

LATERAL LITHOTOMY PRONE SUPINE OTHER: _____

PERSON COMPLETING FORM: _____

PHONE: _____ **DATE:** _____

PLEASE MAKE SURE THIS FORM IS FILLED IN COMPLETELY AND FAXED WITH A CLEAR, AND MAGNIFIED COPY OF THE INSURANCE CARD TO 866-249-5146 TO ENSURE THAT THE BOOKING IS SCHEDULED.

***Booking FORM is due ONE WEEK in advance**