



Ophthalmology Booking Form

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

Surgeon:		Asst. Surgeon:		Location: <input type="checkbox"/> Manhattan <input type="checkbox"/> 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:		<input type="checkbox"/> Male <input type="checkbox"/> 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

Complex Cataract Surgery – 66982	Cataract Surgery with IOL 1 st Stage – 66983	
Cataract Surgery with IOL 1 st Stage – 66984	Corneal Transplant (Keratoplasty Penetrating) – 65730	
PKP (Corneal Transplant) – 65755	Pterygium (Ocular Reconstruction Transplant) – 65780	
Goniotomy – 65820	Incision of Tear Duct Opening – 68440	
Incision of Inner Eye Adhesions – 65865	Lysis of Adhesions – 65870	
Removal of Eye Lesion – 65420	Repair of Iris – 66680	
Suture of Iris & Ciliary Body – 66682	Removal of Iris – 66630	
Incision of Eye – 66172	Glaucoma – 66170	

Other Procedure Descriptions: _____

Other CPT Codes: _____

OS/Left OD/Right

Diagnosis (ICD-10): _____

Lens Size: _____ Model: _____ Brand: _____

Other Supplies/Equipment/Implants: _____

Antibiotics to be administered before Pre-Op: No Yes: _____

Rep. Requested	Name of Rep:
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Please fax a copy of the front and back of the patient's insurance card.

Person completing form _____ Phone: _____ Date: _____