



Podiatric Surgical 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

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

Other Procedures: _____ CPT Codes: _____

Other CPT (ICD-10): _____ Other Diagnosis : _____

Description: _____

Diagnosis (ICD-10): _____

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: _____