



ENT Surgical Booking Form

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

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

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

Person completing form _____ Phone: _____ Date: _____