Gramercy Surgery Center

BOOKING: 646-350-3338
FAX: 212-257-7004

SURGICAL BOOKING FORM

LOCATION(S): □ MANHATTAN □ QUEENS
SURGEON(S): _____
DATE OF SURGERY: _____ TIME: _____ ESTIMATED LENGTH: _____
PATIENT'S NAME: _____ □ Male □ Female
EMAIL: _____.
RACE: _____ ETHINICITY: _____
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 212.257.7004 TO ENSURE THAT THE BOOKING IS SCHEDULED.

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

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The Gramercy Difference