# Podiatric Surgical Booking Form

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

| | | | |
|---|---|---|---|
| **Surgeon:** | **Asst. Surgeon:** | **Location:** ☐ Manhattan ☐ 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:** | ☐ **Male** ☐ **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) | |
| Ostectomy, partial excision, 5th metatarsal head (28110) | | Capsulotomy (28270) | |
| Anthroplasty (correction of hammer toe) (28285) | | Hallus rigidus correction with cheilectomy, debridement & capsular release of 1st MTP (21335) | |
| 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 offracture, phalanx or phalanges, other than great toe, includes internal fixation (28525) | |
| Open treatment oftarsonetarsal 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:** _____