



BOOKING: 212-254-3570
FAX: 866-249-5146

SURGICAL BOOKING FORM

LOCATION(S): MANHATTAN QUEENS

SURGEON(S): _____

DATE OF SURGERY: _____ TIME: _____ ESTIMATED LENGTH: _____

PATIENT'S NAME: _____ Male Female

EMAIL: _____

RACE: _____ ETHNICITY: _____

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 866-249-5146 TO ENSURE THAT THE BOOKING IS SCHEDULED.

*Booking FORM is due ONE WEEK in advance