Gramercy Surgery Center

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

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

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The Gramercy Difference