

Patient Booking Data Form

**** Patients :Please fill out only the ** underlined portions below:**

****Name:** _____ If Minor, Parents Name: _____

****Address:** _____

****Home Phone:** _____ ****Cell Phone:** _____

****Work Phone:** _____ ****Birth Date:** _____ **** Age:** _____ ****Sex:** () Male () Female

****Social Security #:** _____ ****Marital Status:** () Single () Married () Divorced () Widowed

****Emergency Contact Name:** _____ ****Contact #:** _____

****Insurance CompanyName:** _____ ****ID#** _____

****Insurance Company Billing Address:** _____

Accident Related: () Yes (X) No Accident Insurance Info: N/A

Adjustor Name: _____ Claim #: _____

Adjustor Phone #: _____ Carrier Address _____

FOR OFFICE USE ONLY(patients do not need to fill out):

Pre-Cert Required: () Yes () No Pre-Cert Obtained: () Yes () No

Pre-Cert Contact Name: _____ Phone # _____

Pre-Cert #: _____ Out Of Network Benefits: () Yes () No

Deductible: _____ Co-Pay: _____

ICD9 / Diagnosis: _____ CPT / Procedure: _____

Pre-Op Data Required: () None () Medical Clearance () Pre-Op Labs () X-Ray ()EKG

Studies Ordered: () None () CBC () CHEM8 () EKG () PT/PTT () CXR () LFT's () Dig Level () Other _____

Anesthesia Type: () Gen () Mac () IV Sed () Local () Block () Other _____

Surgery Date: _____ Surgery Time: _____ Surgeon: _____ Assistant: _____

Special Equipment/Implants needed: () Yes () No (if yes, please list below and call RN/Manager to Confirm)

Primary Care Physician: _____ Physician Phone # _____

* Please Fax Completed Form To Alliance Surgical Center - Fax # (407) 708-5390.