



Westside ASC Booking Sheet

450 West 31st Street, New York, NY, USA

Phone: 646-930-2700 Fax: (646)609-1350 Please fax with a copy of insurance card

Surgeon:	Procedure Date:	Procedure Request Time:
-----------------	------------------------	--------------------------------

Today's Date:	Scheduler/ Contact:	Scheduler Phone Number:
Legal Name:	First Name	DOB:
Home Phone:	Cell Phone:	Email:
Street Address:	City/ State/ Zip:	
SSN:	Gender:	
PCP Name:	PCP Phone:	

Interpreter No Yes If yes, what language: _____

Race: White Black/ African American Spanish/ Hispanic/ Latino American Indian/ Alaska Native Asian
 Native Hawaiian/ Pacific Islander Multiracial Other: _____

Special Needs: Wheelchair Nursing Home Patient Power of Attorney Healthcare Proxy

INSURANCE INFORMATION

<u>PRIMARY INSURANCE INFORMATION:</u>
Plan: _____
Insured ID No.: _____
Group No.: _____
Referral / Pre-Cert No. (if applicable): _____

<u>SECONDARY INSURANCE INFORMATION:</u>
Plan: _____
Insured ID No.: _____
Group No.: _____
Referral / Pre-Cert No. (if applicable): _____

PROCEDURE INFORMATION

Assistant Surgeon: _____

Admission Type: AMB Anesthesia Type: _____ Length of Procedure: _____

Laterality: Right Left

Procedure	CPT		
	CPT		
	CPT		

Diagnosis(es)	ICD10		
	ICD10		
	ICD10		
	ICD10		

Allergies: _____

Len Size: _____ Model: _____ Brand: _____

Latex Allergy Has Pacemaker/ Defibrillator Diabetic Pregnant

Special Equipment/ Supplies/ Implants: _____

Surgeon Signature: _____ Surgeon Name: _____ Date: _____ Time: _____