CARES SURGICENTER BOOKING SHEET

B00	KING OFFICE	732) 792-3041 I	FAX (732) 565	5-540)8 VOI	Œ	
		RANCE CARD FRONT AND BACK						
LAST NAME			FIRS	TNAME				
SS#		DOB				SEX CHECK BOX	□ M □ F	
ADDRESS	STREET		CITY					
			STAT	E		ZIP		
HOME PHONE			Al		□ WC			
E-MAIL ADDRESS					□ CE	LL		
SURGERY INCURINATION				E OF TIME OF AVAILAB			SURGICAL TIME NEEDED	
PHYSICIAN NAME							1,12222	
DIAGNOSIS			l	I.				
PLANNED								
PROCEDURE								
						1		
SURGICAL SITE	RIGHT	□ LEFT				□ N/A		
CPT CODES IF KNOWN SPECIAL NEEDS								
SPECIAL NEEDS CHECK BOX(S)	□ ASSISTANT	□ C-ARM MINI	L	☐ C-ARM LARGE		□ LASER		
GYN EQUIPMENT CHECK BOX(S)	☐ TRUCLEAR	☐ THERMA CHOICE	□ H	□ HTA				
IMPLANTS	☐ YES IF YE	ES, LIST						
SPECIAL INSTRUMENTS		ES, LIST						
INSTRUMENTS	□ NO							
ANESTHESIA PLANNED	☐ GENERAL ☐ REGIONAL ☐ GENERAL WITH NERVE BLOCK NERVE BLOCK						□ SPINAL	
CHECK BOX	□ LOCAL ONLY NO ANESTHESIOLOGIST	□ SEDATION (M		IV REGIO	NAL (E		□ EPIDURAL	
CHECK BOX	PRIMARY INSURANCE INFORMATION PATIENT'S RELATION							
INSURANCE CO				PHONE # I	F UNIC		O INSURED SELF	
NAME ADDRESS				PRECERT/REFERRAL			SPOUSE DEPENDENT	
							OTHER	
NAME OF INSURED	COMPLETE IF NOT SE	ELF		DATE OF BIRTH	=			
SS#		ID#			GRO	JP#		
SECONDARY INSURANCE INFORMATION PATIENT'S RELATION TO INSURED								
INSURANCE CO				PHONE # IF UNION			SELF SPOUSE	
ADDRESS				PRECERT/R	REFERF	RAL	DEPENDENT	
NAME OF	COMPLETE IF NOT SE	ELF		DATE OF	=		OTHER	
INSURED SS#		ID#		BIRTH	GROU	JP#		
WORKERS COMP/ MVA INSURANCE CLAIM # DATE OF INJURY								
ADJUSTER'S					PHON	N ⊏ #		