The Center for Ambulatory Surgery
1450 Route 22 West
Mountianside, NJ 07092

SCHEDULING FORM / PRE-ADMISSION

SchedulingTel. # : 908-233-8577
Fax #: 908-233-5916

PLEASE PRINT CLEARLY

PROCEDURE DATE: _____ REQUESTED TIME: _____

Surgeon: _____ Assistant: _____

PATIENT'S INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____ AGE: _____

Address: _____ City & State: _____ Zip Code: _____

Gender: (Circle One) M or F SS#: _____ DOB: _____

Home Telephone #: _____ Work #: _____ Cell #: _____

If patient is a minor, Parent or Guardian's Name: _____ Patient's Email: _____

Patient Speaks English? YES NO If No, Language Spoken: _____

EMERGENCY Contact Name: _____ Relationship: _____

Phone #: _____

MEDICAL INFORMATION: (PLEASE RECORD PATIENT'S ACTUAL HEIGHT AND WEIGHT)

Anesthesia Type: (Check Off) ☐ General ☐ MAC ☐ Spinal ☐ Local

ASA CLASS _____ HEIGHT _____ WEIGHT _____ BMI _____

NOTE: ALL LABS/EKG/MEDICAL CLEARANCE MUST BE REC'D AT LEAST 1 WEEK PRIOR TO SURGERY TO AVOID POSSIBLE CANCELLATION.
IT WILL BE AT THE DISCRETION OF ANESTHESIA TO CANCEL THE CASE IF INFORMATION IS NOT REC'D OR RESULTS ARE ABNORMAL.

LAB: (Check Off) ☐ CMP ☐ CBC ☐ PT/PTT ☐ EKG ☐ CHEST X-RAY Testing Location: _____

Medical Clearance w/Dr. _____ Phone: _____

ALLERGIES: (Drug/Food/Latex /Other)_____ Fax: _____

DIAGNOSIS: _____ ICD 10 Code: _____

SITE Location: (If applicable circle one) Left Right Bilateral TIME REQ.: _____

PROCEDURE: _____ CPT Code: _____

_____ CPT Code: _____

_____ CPT Code: _____

Special Equipment/Rep Needed:_____

X-Ray: O Yes O NO Implantable Device Needed: BE SPECIFIC_____

INSURANCE INFORMATION: ** PLEASE PROVIDE A COPY OF INSURANCE CARD - BOTH FRONT AND BACK WITH BOOKING SHEET **

Type of Insurance: (Circle One) Commercial PIP W/C LOP

Primary Ins:	Secondary Ins:
ID / Claim # :	ID / Claim # :
Group # :	Group #:
Subscriber's Name:	Subscriber's Name:
SS#: DOB:	SS#: DOB:
Relationship:	Relationship:
Adjuster's Name: Benefits Phone #:	Adjuster's Name: Benefits Phone #:
DOA: (If Applicable) Precert Auth.#:	DOA: (If Applicable) Precert Auth.#: