Hudson Yards Surgery Center 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

PRIMARY INSURANCE INFORMATION:

Plan:_____

Insured ID No.:_____

Group No.:_____

Referral / Pre-Cert No. (if applicable): _____

SECONDARY INSURANCE INFORMATION:

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:_____