The Center For Ambulatory Surgery
1450 Route 22 West
Mountainside, NJ 07092

Phone #: 908-233-8577
Fax #: 908-233-5916

Scheduling Form/Pre-Admission

PROCEDURE DATE: ____________ **REQUESTED TIME:** ____________

Surgeon: ____________ **Assistant:** ____________

Patient's Information

Last: **First:** **Middle Initial:** **Age:**

Address: **City & State:** **Zip Code:**

Sex: M or F (circle) **SS#:** **DOB:**

Home Phone #: **Work #:** **Cell #:**

Patient E-mail:

IF PATIENT IS A MINOR, PARENT OR GUARDIAN'S NAME:

PATIENT SPEAKS ENGLISH? □ Yes □ No **If No, Language Spoken:** ____________

Emergency Contact: **Relationship:**

Phone #: ____________

Medical Information

Anesthesia Type: □ **General** □ **MAC** □ **Spinal** □ **Local**
Pre-Admission Testing: □ **CBC** □ **CMP/Lytes** □ **PT/PTT** □ **EKG** □ **Chest X-ray**
Medical Condition: □ **Hypertension / Cardiac Disease** □ **Diabetes** □ **MRSA** □ **Respiratory Disease**

Height: **Weight:** **BMI:** ____________ **ASA Class:** ____________

□ **MEDICAL / CARDIAC CLEARANCE W/ DR.** ____________

Phone #: ____________ **Fax #:** ____________

ALLERGIES: (Medications / Food / Latex / Other) ____________

ALL LABS, EKG & MEDICAL CLEARANCE MUST BE AT THE CENTER BY 12PM THE DAY PRIOR TO SURGERY

Diagnosis: **ICD10 Code:**

SITE: (if applicable) □ **LEFT** □ **RIGHT** □ **BILATERAL** **Time Required:**

Procedure: **CPT Code:**

CPT Code:

□ **C-arm** □ **Mini C-arm** **Special Equipmemt:**

□ **Surgical Site Shaving required in Pre-op**

Implantable Devices Needed :

Company: **Rep Name & #:** **Quantity:**

Insurance Information □ **A COPY OF INSURANCE CARD, FRONT & BACK FAXED WITH BOOKING SHEET**
□ **LOP Sent with Booking Sheet**

Primary Ins: **ID #:**

Subscriber's Name: **Relationship:** **DOB:**

Facility Auth #: **Insurance Phone #:**

Secondary Ins: **ID #:**

Subscriber's Name: **Relationship:** **DOB:**

Facility Auth #: **Insurance Phone #:**

WC Date of Accident: **Claim #:**

Adjuster Name: **Phone #:**

Address:

PIP DOI: **Claim #:**

Adjuster Name: **Phone #:**

Address: