RETINAL AMBULATORY SURGERY CENTER OF NEW YORK,INC.

FAX# (212)772-6883

	PROCEDURE(S)	CPT CODE(S)
1.SURGEON:		
ASST. SURGEON:		
2.SURGEON:		
ASST. SURGEON:		

Date of Surgery:_____/____/_____ **Req. Time**__:__ **AM**__ **PM**__ **Duration Time**_____ **Stay**_____ **day(s)**

Date:____/____/_____

Patient Last Name_____**(M**___ **F**___**) SS#**_____-_____-_____

Patient First Name _____**Marital Status(M**___ **S**___**)** **D.O.B.**___/_____/_____

TEL:Residence (___**)** _____ **Work(**____**)** _____ **Ext:**_____ **Other (**____**)**_____

Street Address _____ **APT#**_____ **City**_____ **State**_____ **Zip**_____

Parent/Guardian:

Emergency Contact/Spouse : **Tel ( )**

Admission Date_____/_____/_____

Anesthesia(check one): Mac ____ **Mac/Topical** ____ **Local** ____ **Topical** ____ **Block** ____

Requested by:

Surgical Coordinator: **Phone (**__**)**

PLEASE LIST THE ICD 10 CODES

DIAGNOSIS (ES) _____ **ICD-10** _____
FOR PRECERT _____ **ICD-10** _____
_____ **ICD-10** _____
_____ **ICD-10** _____

Left Eye ____ **Right Eye** ____ **Bilateral** _____

Allergies _____ **Latex Sensitive** _____

Special Equipment/Instructions: _____

Comments:

SPECIAL NEEDS: **Types of Needs**	**With Dementia** __ **Behavioral Problem** __ **Oxygen Dependent** __ **Defibrillator** __ **Blind** __ **Dialysis** __ **Hearing Impaired** __ **Needs a Wheelchair** __ **Latex Allergy** __

PLEASE NOTE: ALL CASES MUST HAVE THE PRE-TESTING RESULTS AND THE PRE-ADMISSION FORMS 48 HOURS IN ADVANCE. ALSO , ALL INSURANCE INFORMATION MUST BE COMPLETE WITH AUTHORIZATION NUMBER ATTACHED

Insurance Information Physician Accepts Insurance: Yes__ No __ **OUT OF NETWORK** ____ **SELF-PAY**____

Primary Insurer _____ Secondary Insurer _____

Policy Holder's Name _____ Policy Holder's Name _____

Relation to Patient_____ Relation to Patient _____

Policy#_____ Group _____ Policy# _____ Group _____

Ins. Tel#_____ Effect Date_____ Ins. Tel#_____ Effect Date _____

PCP Tel#_____

PRECERT #_____ DATE_____ PRECERT #_____ DATE _____

Comments, No-Fault/Workers Comp. Information_____

H&P to be provided by:_____ **Office Phone Number:**_____

RETINAL AMBULATORY SURGERY CENTER OF NEW YORK,INC.

FAX# (212)772-6883

	PROCEDURE(S)	ICD 10 CODE(S)
1.SURGEON: BEN Z. COHEN		
ASST. SURGEON:		
2.SURGEON:		
ASST. SURGEON:		

Date of Surgery:_____/____/_____ **Req. Time**__:__ **AM**__ **PM**__ **Duration Time**_____ **Stay**_____ **day(s)**

Date:____/____/_____

Patient Last Name_____**(M**___ **F**___**) SS#**_____-_____-_____

Patient First Name _____**Marital Status(M**___ **S**___**)** **D.O.B.**____/_____/_____

TEL:Residence (___**)** _____ **Work(**____**)** _____ **Ext:**_____ **Other (**____**)**_____

Street Address _____ **APT#**_____ **City**_____ **State**_____ **Zip**_____

Parent/Guardian:

Emergency Contact/Spouse : **Tel ( )**

Admission Date_____/_____/_____

Anesthesia(check one): Mac ____ **Mac/Topical** ____ **Local** ____ **Topical** ____ **Block** ____

Requested by:

Surgical Coordinator: **Phone (**__**)**

PLEASE LIST THE ICD 10 CODES

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FOR PRECERT _____ **ICD-10** _____
_____ **ICD-10** _____
_____ **ICD-10** _____

Left Eye ____ **Right Eye** ____ **Bilateral** _____

Allergies _____ **Latex Sensitive** _____

Special Equipment/Instructions: _____

Comments:

SPECIAL NEEDS: **Types of Needs**	**With Dementia** __ **Behavioral Problem** __ **Oxygen Dependent** __ **Defibrillator** __ **Blind** __ **Dialysis** __ **Hearing Impaired** __ **Needs a Wheelchair** __ **Latex Allergy** __

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Insurance Information Physician Accepts Insurance: Yes__ No __ **OUT OF NETWORK** ____ **SELF-PAY**____

Primary Insurer _____ Secondary Insurer _____

Policy Holder's Name _____ Policy Holder's Name _____

Relation to Patient_____ Relation to Patient _____

Policy#_____ Group _____ Policy# _____ Group _____

Ins. Tel#_____ Effect Date_____ Ins. Tel#_____ Effect Date _____

PCP Tel#_____

PRECERT #_____ DATE_____ PRECERT #_____ DATE _____

Comments, No-Fault/Workers Comp. Information_____

H&P to be provided by:_____ **Office Phone Number:**_____