The Miriam Hospital
A Lifespan Partner

Surgical Services Booking Office

Patient Data: **Changes to Form: Choose One Date:**

Name: Gender: M ☐ F ☐ Date of Birth: Age: Social Security: - -

Patient Address: City: State: Zip:

Home Phone: - - Work Number: - - Other Phone Number: - -

Interpreter Needed: ☐ Yes ☐ No Preferred Language:

Surgical Information:

Surgery Date: Length of Surgery: Time Requested:

Surgeon: Office Number: - - Fax Number: - -

Diagnosis: ICD# / / / CPT Code: / /

Procedure: Location: MOR ☐ SCOR ☐ Side: ☐ Right ☐ Left ☐ Bilateral ☐ N/A

Comments:

Assistant: RNFA Needed ☐ Yes ☐ No

Equipment:

Radiology: **Choose One** Table **Choose One** Other:

Implant: Miscellaneous: TMH Vendor & Rep:

Anesthesia

Type: **Choose One** Position: **Choose One** Other:

Block for Post-Op Pain ☐ Yes ☐ No

Specialty Precautions:

Latex Allergy: ☐ Yes ☐ No

Admission Data:

Type of Admission: **Choose One** Admission Time: Inpatient Level of Care:

PCP: ☐ ICU ☐ Intermediate ☐ Floor

Admission Date: / /

PAT – Preferred Day/Time:

Insurance Information:

Primary Insurance **Choose One** Other: Secondary Insurance:

Primary Insurance Subscriber: Policy # Phone: - -

Secondary Insurance Subscriber: Policy # Phone: - -

Workers' Compensation:

Date of Injury: / / Address: Phone: - -

Employer: Address: Phone: - -

Insurance Company:

Booking Office Use Only: MR # _____ Account #_____