THE NEW YORK EYE AND EAR INFIRMARY
OUTPATIENT LASER CENTER FORM

Web Form

(866) 500-3977

PROCEDURE (S)	CPT Code(s)
1 SURGEON:__________________________ ____________________________________	__________________

Date of Surgery ________/______ **Req. Time** ______ AM ❑ PM ❑

Patient Last Name ____ **(M ❑ F ❑) Unit #** ________________________

Patient First Name ______________________________ Marital Status (M ❑ S ❑) **DOB** ______________ **Age:**______

TEL: Residence _________________________ **Work** ____________________**Ext:**_____ Other ________________________

Street Address______________________________________ APT # _______________ SS# ______-______-____________

City __________________________________ State ________ Zip _________________

Emergency Contact ____ Tel________________________

DIAGNOSIS (ES) FOR PRECERT		
	____________________________________	ICD-9 ______________
	____________________________________	ICD-9 ______________
	____________________________________	ICD-9 ______________
	____________________________________	ICD-9 ______________

Left ❑ Right ❑ Bilateral ❑

Allergies ____

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 ____/____/_____
If HMO, who is PCP _____________________________	If HMO, who is PCP _________________________________
PCP Tel # ____	PCP Tel # ____________________________________
Employer ____	Employer ____
Employer Tel # ( )___________________________	Employer Tel # _ _ ____________________________
PRECERT # ____________________ Date ______________	PRECERT # _____________________ Date ____________

Comments, No-Fault/Workers Comp. Information ____

Physician Orders:

No Orders Indicated ____________

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Physician Signature