

**NORTH SH ORE UNIVERSITY HOSPITAL
300 COMMUNITY DRIVE
MANHASSET, NY 11030
INTERVENTIONAL RADIOLOGY**

OUTPATIENT BOOKING INFORMATION

PATIENT INFORMATION:

LAST NAME _____ FIRST NAME _____

DOB _____ ALLERGIES _____

HOME PHONE#(____) _____ WORK PHONE#(____) _____

SOCIAL SECURITY # _____ MEDICAL RECORD # _____

INSURANCE INFORMATION:

PRIMARY INS. CARRIER _____ INS. PLAN _____

POLICY # _____ POLICY HOLDER'S NAME _____

INSURANCE CO. PHONE # (____) _____

PRE-CERTIFICATION NUMBER: _____

SECONDARY INS. CARRIER _____ INS. PLAN _____

POLICY # _____ POLICY HOLDER'S NAME _____

INSURANCE CO. PHONE # (____) _____

PRE-CERTIFICATION NUMBER: _____

PROCEDURE INFORMATION:

REFERRING MD _____ PHONE # (____) _____

FAX # (____) _____ PROCEDURE _____

CPT CODE _____ DIAGNOSIS _____

ICD 9 CODE _____

ADDITIONAL PATIENT INFORMATION _____

(TO BE COMPLETED BY INTERVENTIONAL RADIOLOGY DEPT)

APPOINTMENT DATE _____ TIME _____