# NEW YORK EYE AND EAR INFIRMARY
# OF MOUNT SINAI
# OUTPATIENT LASER CENTER FORM
**Telephone (646)943-7960 Fax (646) 943-7968**

PROCEDURE(S) ________________ CPT CODE(S)

SURGEON: ________________ DATE OF SURGERY __________ REQ. TIME ________ AM PM

Patient Last Name: ________________ First Name: ____________ (M F) Unit No.

D.O.B.: ____________ Age: ______ Marital Status ( M S) S.S. No. _____/ _____/

Address: ________________ APT. No.: ______ City: ____________ State: ______ Zip:

Telephone: (H) (___) ____________(W): ( ___) ____________ EXT.: ________(C): ( ___)

EMERGENCY CONTACT NAME: ________________ Phone No. (___)

DIAGNOSIS (ES) For PRECERT ________________ ICD-10

________________ ICD-10

________________ ICD-10

Eye: ☐ Right ☐ Left ☐ Bilateral Allergies: ________________

Primary Insurer ________________

Policy Holder's Name ________________

Relation to Patient ________________

Policy No. ________________

Ins. Tel No. __________ Eff. Date ______

If HMO, who is PCP ________________

PCP Tel. No. ________________

Employer ________________

Employer Tel. No. ________________

PRECERT No. ________________

Secondary Insurer

Policy Holder's Name

Relation to Patient

Policy No. .

Ins. Tel No. __________ Eff. Date

If HMO, who is PCP ________________

PCP Tel. No.

Employer

Employer Tel. No.

PRECERT No.

Comments, No-Fault/Workers Comp. Information ________________

PHYSICIAN ORDERS: Eye drops: ☐ Right ☐ Left ☐ Both One drop Q ____ mins. X ______Dose(s)

☐ Mydfrin 2.5% ☐ Mydriacyl 1% ☐ Iopidine 1% ☐ Pilocarpine 2% ☐ Proparacaine 0.5% ☐ Pred Forte 1%

Other Medications (list): ________________ ☐ IOP Measurement ☐ Visual Acuity Measurement

☐ **No Orders Indicated**

**Physician Signature:** ________________ Date and Time:.

Print or Stamp Name:

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