Dr. Eric J. Plumley DPM

PATIENT REFERRAL INTAKE FORM

Please complete all applicable fields and send this form with the required insurance-card images.

REQUIRED WITH REFERRAL: Attach clear images/copies of the front AND back of the patient's insurance card(s), and document the patient's chief complaint below.

1. PATIENT DEMOGRAPHICS

Patient full legal name: _____	**Date of birth:** _____
Preferred name (if applicable): _____	**Sex:** _____
Street address: _____	**Apartment/Unit:** _____
City: _____ **State:** _____ **ZIP:** _____	**Phone:** _____
Email: _____	**Preferred contact:** [ ] Phone [ ] Text [ ] Email
Parent/guardian (if applicable): _____	**Guardian phone:** _____

2. INSURANCE INFORMATION — ATTACH FRONT AND BACK IMAGES

Primary insurance company: _____	**Member/ID number:** _____
Policyholder name: _____	**Policyholder DOB:** _____
Group number: _____	**Relationship to patient:** _____
Secondary insurance (if any): _____	**Member/ID number:** _____
Referral / authorization required? [ ] Yes [ ] No [ ] Unknown	**Authorization # (if available):** _____

Insurance images included: [ ] Primary front [ ] Primary back [ ] Secondary front [ ] Secondary back

3. REFERRAL DETAILS & CHIEF COMPLAINT

Referring provider: _____	**Specialty:** _____
Referring practice / facility: _____	**Phone:** _____

Fax: _____ **Email:** _____

Reason for referral / chief complaint (required):

_____

_____

Location / side: [ ] Right [ ] Left [ ] Bilateral **Duration:** _____ **Prior treatment / imaging:** _____

Relevant diagnosis / ICD-10 (if known): _____ **Urgency:** [ ] Routine [ ] Urgent

4. RECORDS & REFERRING OFFICE CONTACT

Records sent with referral: [ ] Office notes [ ] Imaging/report [ ] Labs [ ] Other: _____

Referring staff contact: _____ **Direct phone:** _____ **Date sent:** _____

Additional notes / scheduling considerations: _____