

Physician Concierge Services - Intake Form

Telephone: 800-431-5151 / 508-856-5656 Fax: 508-334-7616: 508-334-8317: 508-334-1486

Today's Date:

PCP / Referring MD:

Phone:

Fax:

Contact Name:

Priority of Request: (check one below)

 Urgent [24-48 hrs.] ***Medical Reason for Urgency**
***Requires clinical notes & recent imaging**
 ASAP [7-10 days]

 2nd Opinion

 Consult

Interpreter Needed: Y N

Language:

Specialty Clinic:

Preferred Provider:

Preferred Location:

PATIENT:	
DOB:	SEX:
ADDRESS:	
EMAIL:	
PHONE: (H)	(C)
PRIMARY INSURANCE:	
POLICY NUMBER:	
GUARANTOR (NAME/DOB): (UNDER 18)	
SECONDARY INSURANCE:	
POLICY NUMBER:	
GUARANTOR (NAME/DOB): (UNDER 18)	
SUBSCRIBER (NAME/DOB):	
RACE:	ETHNICITY OR ETHNIC BACKGROUND
American Indian or Alaska Native _____	American _____
Asian _____	Brazilian _____
Black or African American _____	Korean _____
Hispanic or Latino _____	Other _____
Not Hispanic or Latino _____	
Native Hawaiian or Pacific Islander _____	
White _____	
Decline to Answer _____	Decline to Answer _____

****Note: To expedite scheduling appointments, please make sure the following information is sent to PRS.**

- Complete and fax any clinical notes, labs, x-rays, MRI's, Cat Scans.
- Questionnaires for Mammography, Cat Scans, Nuclear Med must be filled out and faxed with referrals.

Diagnosis:	ICD 10 CODE:
Prior Authorization:	Contact Name:
Dates:	Telephone:
Number of visit:	
*Required for MRI's and CT Scan's	
MVA / Worker's Comp:	Date of Injury:
Claim Number:	
Insurance Co:	Telephone:
Address:	
Adjuster's email:	