NEW ENGLAND CENTER FOR MENTAL HEALTH

119 Russell Street, Suite 30
Phone: (978) 679-1200
Fax: (978) 486-4037

Patient Demographics

Name: ______________________________
Date of Birth: _________________________
Gender: ______________________________
Social Security # ______________________
Address: _____________________________
Zip Code:_____________________________
Work Phone: __________________________
Home Phone: __________________________
Cell Phone: ___________________________
Email: _______________________________
Occupation: ___________________________
School Name: _________________________
Grade: _______________________________
Religion: _____________________________
Language: ____________________________
Racial/Cultural Identity: _______________

Primary Care Provider / Pediatrician Information

PCP: __________________________________
PCP Address: ___________________________
PCP Telephone: _________________________

Primary Insurance: ____________________________
Policy #: _____________________________________
Policy Holder's Name: ________________________
Policy Holder's Date of Birth: __________________
Policy Holder's Social Security#:______________

Behavioral Health/Mental Health Phone #:________________
Customer Service Phone #:______________________________
*(*This information can be located on back of insurance card)*

Pharmacy Information

Pharmacy: ______________________________
Telephone: ______________________________

Agency Involved with the Child / Family:

- ☐ DSS
- ☐ DYS
- ☐ DMH
- ☐ DMR
- ☐ Dept of Health Affairs
- ☐ Domestic Violence
- ☐ Legal Services of Greater Boston

Contact Information:
____

Guardian/Mother Information (If pt. is < 18)

Name: _____________ Occupation: _________
Custody: ___________ Home #: ____________
Work #: ___________ Cell #: ______________
Address: ________________________________

Guardian/Father Information (If pt. is < 18)

Name: _____________ Occupation: _________
Custody: ___________ Home #: ____________
Work #: ___________ Cell #: ______________
Address: ________________________________

Emergency Contact (If pt is >18)

Name: ________________________
Relationship:______________________
Cell#:________________Home#:______________

How do you prefer to have your appointment confirmed?

Email: [ ] Phone: [ ] Text/SMS: [ ]