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: [ ]