



85 First Avenue, Waltham, MA 02451
(781) 647-7246 Fax: (781) 290-0720 www.bostonpaincare.com

DEMOGRAPHIC FACE SHEET

In order for us to maintain current contact information and a complete and current medical history, it is important for you to verify that the information on this form is accurate. Please make any changes below and verify the accuracy of what we have for your electronic health record.

Full Name: _____ **Date of Birth:** _____
SSN: _____ **SEX:** _____ **Marital Status:** _____
Address: _____
Phone #: _____ **Work Phone #:** _____
Cellphone #: _____ **Email Address #:** _____
Preferred method of Contact: Email Home Phone Cell Phone
Pharmacy Pref: _____
 (include location)
How did you hear about us? _____
PCP: _____ **PCP Phone#:** _____
PCP Address: _____
Referring Physician: _____ **Referring Phone#:** _____
Referring Address: _____

This is what we have on file for your insurance:

Primary	Secondary
Group #:	Group #:
Policy #:	Policy #:

Name of Primary Insurance Policyholder: _____

Relationship to Primary Insurance Policyholder: Self Spouse Child Other: _____

Injury is: Work Related: Car Accident: Other: _____

Date of Injury if it applies: _____ **State in which the accident occurred:** _____

Employer Name: _____ **Employer Address:** _____

Emergency Contact Name: _____ **Relationship:** _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

I authorize the release of any previous results or images in the event it is needed to help with the diagnosis and plan of care for further treatment. I permit a copy of this authorization to be used in place of the original. I understand and acknowledge that I am personally responsible for the services rendered at this facility. We will bill your insurance carrier as a courtesy. In the event of a non-payment, I understand I will be responsible for any outstanding balances.

Patient/Legal Guardian Signature: **Date:** _____

