



Boston Sports Medicine



PATIENT INTAKE FORM

Patient Information

Last Name: _____ First Name: _____ MI: _____
Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____
Date of Birth: ____/____/____ SSN: _____ Gender: _____
Email: _____ How did you hear about us? _____

Emergency Contact

Name: _____ Relationship: _____ Phone: ____-____-____

Problem

Problem Description: _____ Date of Injury: ____/____/____
Referred by: _____ Primary Care Doctor: _____

Insurance

- Primary Insurance: _____ ID #: _____ Group #: _____
Subscriber Name: _____ Relationship: _____ Date of Birth: ____/____/____
- Secondary Insurance: _____ ID #: _____ Group #: _____
Subscriber Name: _____ Relationship: _____ Date of Birth: ____/____/____

For Worker's Compensation ONLY

Case Manager's Name: _____ Phone #: ____-____-____
Employer's Name & Address: _____
Employer's Phone #: ____-____-____ Claim #: _____

For Motor Vehicle & Other Law Suits ONLY

Lawyer's Name & Address: _____
Date of Incident: ____/____/____ Lawyer's Ph. #: ____-____-____ Lawyer's Fx. #: ____-____-____

SIGNATURE: _____ DATE: _____

**1 Braintree Street
1st Floor
Allston, MA 02134
Ph: 617-787-8700
Fx: 617-787-8106**

**14 McGrath Hwy
At Gold's Gym
Somerville, MA 02143
Ph: 617-623-6300
Fx: 617-623-4224**

**36 Arlington Street
at Super Fitness
Watertown, MA 02472
Ph: 617-926-2300
Fx: 617-926-5886**

www.bostonsportsmed.com