PHYSICIAN HEALTH SERVICES

A Massachusetts Medical Society corporation
www.physicianhealth.org

DATE: ________________________ **PHS ID #:_________**

PLEASE PRINT OR TYPE CLEARLY

PERSONAL INFORMATION:

Last Name: ____________________________ First Name: ___________________ Middle Initial: ____ Suffix: _____

Sex: ___________ Date of Birth: ______/______/___________ Degree:______________________________

Marital Status:

☐ ***MARRIED*** ☐ ***SINGLE*** ☐ ***DIVORCED*** ☐ ***WIDOWED*** ☐ ***CO-HABIT***

Spouse/Significant Other (optional): Last Name: ________________________ First Name: _________________________

Primary Specialty: ____________________________________ Second Specialty: __________________________________

☐ Resident - Post Graduate Year 1 2 3 4 5 6 ☐ Medical Student 1 2 3 4

HOME ADDRESS:

Address: ____

City: ______________________________ State: _______ Zip: ___________________

Phone: _____________________________ Fax_______________________Email: _______________________________

WORK ADDRESS

Organization: _____________________________________ Title:______________________________________

Address: ____

City: ______________________________ State: _______ Zip: ___________________

Phone: _____________________________ Ext.: __________ Fax: ________________________________

OTHER ADDRESS:

Address: ____

City: ______________________________ State: _______ Zip: ___________________

Phone: _____________________________ Ext.: ________ Fax: ________________________________

PREFERRED PLACE OF MAIL: ☐ ***HOME*** ☐ ***WORK*** ☐ ***OTHER:*** __________________________________

PREFERRED PLACE OF CONTACT: ☐ ***HOME*** ☐ ***WORK*** ☐ ***OTHER:*** __________________________________

ORGANIZATIONS/HOSPITAL AFFILIATIONS: ____

CURRENT MALPRACTICE CARRIER: ____

Name: ____

Address ____

City: ______________________________ State: _______ Zip: ___________________

PLEASE LIST THE STATES IN WHICH YOU CURRENTLY HOLD A LICENSE:

Massachusetts #: _____________________ Status: ___________________

Other State(s) #: _____________________ Status: __________________

Other State(s) #: _____________________ Status: __________________

REFERRAL SOURCE:

NAME: ____

Address: ____

City: ____________________ State: ______ Zip: ______________

Phone: ____________________ Ext.: ______ Fax: ______________________

THERAPIST: ***NOT APPLICABLE:*** ☐

Last Name: __________________ First Name: ________________ Suffix: ______

Degree: ___________ Title: ______________________________________

Hospital: ____

Address: ____

City: ____________________ State: ________ Zip: ___________

Phone: ____________________ Fax: __________________

PRIMARY CARE PHYSICIAN:

Last Name: ____________________ First Name: _________________ Suffix: ______

Degree: ___________ Title: ______________________________________

Hospital: ____

Address: ____

City: ____________________ State: ________ Zip: ____________

Phone: __________________ Fax: ___________________

ATTORNEY: ***NOT APPLICABLE*** ☐

Last Name: ____________________ First Name: _________________ Suffix: ______

Address: ____

City: ____________________ State: ________ Zip: ___________

Phone: __________________ Fax: ___________________