Sherry Malcomb Gill & Associates

Client Information Form

Client Name:_____ Date:_____

Home Address:_____ City/State/Zip_____

Social Security #____-___-_____ Email Address:_____

Phone Number: ☐ Home_____ ☐ Cell_____ Check to receive messages

Birth Date: _____/_____/_____ Age: _____ Gender: ____Male ____ Female

Marital Status: ☐Single ☐Married ☐Domestic Partner ☐Divorced ☐Separated ☐Widowed

Client's Primary Care Physician_____ Phone: _____

Referred by: _____ Phone: _____

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Your Employer:_____ Work Phone:_____

Address_____ Occupation: _____

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Responsible Party (if other than client):_____

Social Security #:_____/_____/_____ Relationship to client: _____

Birth Date: _____/_____/_____ Home # _____ Cell #_____

Home Address: _____ City/State/Zip: _____

Employer: _____ Work Phone: _____

Address: _____ City/State/Zip: _____

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Health Insurance Coverage (Please provide a copy of your insurance card)

Insurance Company (primary) _____ Phone:_____

Group#_____ Member ID# _____

Authorization #:_____ EAP Authorization: _____

Policy Holder: _____ Relationship to Client: _____

IF MORE THAN ONE INSURANCE COMPANY PLEASE CHECK _____

How Did You Hear About Us: ___Internet ____Social Media ____ Insurance Co. ____ Friend

Authorization to Release Information: (Signature required for insurance purposes)
I hereby authorize the release of any information acquired to in the course of my assessment or treatment to any pertinent insurance company for the sole purpose of receiving the medical benefits to which I am entitled.

Signature of Client or Guardian: _____ Date: _____

Authorization to Assign Benefits to Provider: (Signature required for insurance purposes)
I hereby authorize payment directly to Sherry Malcomb Gill & Associates, all of the medical benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for the payment of the full amount due regardless of benefits paid by my insurance coverage.

Signature of Patient or Guardian: _____ Date: _____

EMERGENCY CONTACT: NAME: _____ **RELATIONSHIP:**_____

PHONE: _____ **PERMISSION TO CONTACT: _____YES _____ NO**