Client Information Sheet
John B. Milnes, M.S.W., P.C.

Please complete this form in its entirety. All information in bold is required.
If the client is a child, please complete with the child's information in the upper section of this page.

NAME: _____ **GENDER:** M / F
Last First Middle

ADDRESS:_____
Street

_____ _____ _____
City State Zip

TELEPHONE: _____ _____ _____
Home Cell Work

SS#: _____ **DATE OF BIRTH:**_____AGE:_____

MARITAL STATUS:_____ **Employer/School:**_____ GRADE:___

EMAIL:_____

Please Circle:
Primary Contact - Home/Work/Cell
Secondary Contact – Home/Work/Cell
****

SPOUSE/PARTNER:_____

ADDRESS (if different than client):_____

DATE OF BIRTH:_____TELEPHONE:_____ _____
Home Cell
Employer:_____ TELEPHONE:_____
****

NEAREST RELATIVE/EMERGENCY CONTACT:_____

PHONE:_____ RELATIONSHIP TO CLIENT:_____

PRIMARY CARE PHYSICIAN:_____CITY/STATE:_____

REFERRED BY:_____

Insurance Information

PRIMARY INSURANCE:_____PHONE:_____

INSURED NAME:_____DATE OF BIRTH:_____

RELATIONSHIP TO CLIENT:_____

POLICY/ID#:_____GROUP NAME/#:_____

SECONDARY INSURANCE:_____PHONE:_____

INSURED NAME:_____DATE OF BIRTH:_____

RELATIONSHIP TO CLIENT:_____

POLICY/ID#:_____GROUP NAME/#:_____

I authorize the following people access to the information I specify below. By doing so, you are indicating that you authorize the release of your scheduling or account information to them, as needed. Be sure to include your spouse/partner if you wish that person to make/change appointments and/or have access to billing information.

NAME:_____ Appointment Info:_____ Billing Info:_____
initial initial

NAME:_____ Appointment Info:_____ Billing Info:_____
initial initial

AUTHORIZATION/ASSIGNMENT INFORMATION

- I authorize John B. Milnes, M.S.W. to release information to my physician or insurance company for the purposes of continuity of my medical care. I assign to and authorize payment of medical benefits to be made directly to the provider of services. However, I fully understand that I am financially responsible to John B. Milnes, M.S.W., for charges not covered by this assignment.
- I was provided with and have read and understand the Client Information Sheet.
- I understand the appointment/cancellation policy of this office and agree to pay any missed/late cancellation fees as stated in the Client Information Sheet.
- I agree to participate in the therapy process in accordance with the terms explained to me.
- I understand that I have the right to request the full Notice of Privacy Practices.
- I understand I am fully responsible for payment on my account. If there is another party who will be accepting responsibility for any balances on my account, I will let the office know and understand this person will need to sign a Financial Agreement.

PRINT NAME:_____

SIGNED:_____ **DATE:**_____

If Client is a child, Please complete the following section:

MOTHER'S NAME:_____

DATE OF BIRTH:_____SS#:_____

ADDRESS (if different than client):_____

EMPLOYER:_____

TELEPHONE:_____
Home Work Cell

FATHER'S NAME:_____

DATE OF BIRTH:_____SS#:_____

ADDRESS (if different than client):_____

EMPLOYER:_____

TELEPHONE:_____
Home Work Cell

Please check appropriate column:

Adults with whom the child is living		Non-residential adults involved with child	
Natural Mother:	( )		( )
Natural Father:	( )		( )
Stepmother:	( )		( )
Stepfather:	( )		( )
Adoptive Mother:	( )		( )
Adoptive Father:	( )		( )

Other:_____

Sibling Information

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____