Completion of Entire Form is Required for Registration.

Patient Information

Today's Date: ___________________Patient Name: ____

Patient Date of Birth: ___________________ Age: _____________ Lives With: ____________________________

Patient Address:____

Phone Numbers: ____

Guardian Email Address: ____

Referring Physician: ____ Phone #: ___________________________

Referring Physician Type: ____ Family Practice, ____ Internal Medicine, ____ Pediatrician,

____ Developmental Behavioral Pediatrics, ____ Neurodevelopmental Pediatrics,

____ Child Neurology, ____ Adult or Child Psychiatry, ____ Licensed Clinical Psychology

Diagnosis for ABA Referral: __________________________________ ABA Hours Prescribed: _________________

Date of Diagnostic Evaluation: _______________________________ ASD Level (circle): 1 2 3

NOTE: ***Please bring a copy of all diagnostic assessments and reports to your appointment.***

Billing Information

Name of Responsible Party:*____
Last First Middle

*No third-party billing. Responsible party must be present to sign for financial responsibility.

Address:____

Phone Number(s): ____

Email Address: ____

Primary Insurance**

Insurance Company Name:____

Insurance Company Address:____

Insured's Name:____

Patient's Relationship to Insured:____

Insured's Date of Birth:____

Insured's Employer:_____________________________________Position:___________________________

Policy #:____Group #:_______________________________

Insured's Driver's License #:____

** **A COPY OF INSURANCE CARD AND DRIVER'S LICENSE REQUIRED**

Secondary Insurance Here:
Please provide same information as primary.

____
____
____

Patient Background Information

List all Medical/Psychological Diagnoses: ____

____

List all Medications/Dosages: ____

List Relevant Medical/Psychological Family History: ____

____

____

Sleeping Issues Related to ASD: ____

Eating Issues Related to ASD: ____

List all Known Allergies: ____

Special Dietary Needs: ____

List all Current Therapies: ____

List all Discontinued Therapies/Dates: ____

____

School Status: _________________ Grade: _________ Classroom Setting: ________________________________

Services Received at School: ____

NOTE: ***<u>Please bring a copy of all school-based assessments and behavior plans to your appointment.</u>***

Marital Status of Parents: _______________________ Child Custody Status: _______________________________

List Active or Pending Legal Disputes/Lawsuits Pertaining to Patient and/or Family: ________________________

____

List All Individuals Living in Patient's Home: ____

____

Ages of Siblings Living in Home: ____

Behavior Concerns at Home: ____

____

____

Behavior Concerns at School: ____

____

____

Behavior Concerns in Community: ____

____

Favorite Activities: ____

____

Favorite Toys, Games, Movies, etc.: ____

____

Favorite Edible Treats: ____

____

Please list any cultural or spiritual concerns that need to be discussed prior to starting ABA therapy.

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____

Form Completed By:

____
(Signature) (Relationship to Patient)

____
(Date)