Pebblebrook
Pediatric Behavioral Therapy, LLC

Completion of Entire Form is Required for Registration.

Patient Information

Date: _____Patient Name: _____

Patient Date of Birth: _____ Age: _____ Lives With: _____

Patient Address:_____

Phone Number(s): _____

Primary Email Address: _____

Referring Physician: _____ Phone #: _____

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

____ Developmental Behavioral Pediatrics, ____ Neurodevelopmental Pediatrics,

____ Child Neurology, ____ Child Psychiatrist, ____ Licensed Clinical Psychologist

Diagnosis: _____ 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 Phone Number: _____

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 Current Therapies: _____

List all Discontinued Therapies/Dates: _____

_____

School Status: _____ Grade: _____ Classroom Setting: _____

Does Patient Have School IEP, 504, or BIP: _____

Services Received at School: _____

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

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.

_____

_____

_____

_____

_____

Form Completed By:

_____
(Signature) (Relationship to Patient)

_____
(Date)