



Patient Information

Patient Name: _____ Patient Date of Birth: _____
Patient Address: _____ Sex: _____

Home Phone: _____

Mother/Guardian #1:

Father/Guardian #2:

Name: _____ Name: _____
Address if different: _____ Address if different: _____

Cell phone: _____ Cell phone: _____
Work phone: _____ Work phone: _____
Email: _____ Email: _____

Insurance Information

Insurance Carrier: _____ Employer Name: _____
Member ID #: _____ Subscriber's Name: _____
Behavioral Health Phone #: _____ Subscriber's Date of Birth: _____
Group #: _____ Subscriber's Social Sec. #: _____
Behavioral Health Co-Pay: _____ Secondary Insurance Policy: YES* NO
**Submit all secondary policy info on separate page*

Medical Information

Official diagnosis (ex. F84.0 - Autism Spectrum Disorder): _____
Diagnosing Physician & Credentials: _____
Physician's facility/hospital: _____ Current Medications: _____

Service Information

1. What services are you currently receiving? (Check All That Apply) Early Intervention ABA in home
 ABA at school/center Speech OT Not Currently Receiving Services Other _____
2. What services are you seeking from Partners in Learning? (Check All That Apply) Full-Time ABA Inclusion Program
 Part-Time ABA Inclusion Program Outreach ABA Program (In-Home) Peer/Social Group (At Center)
3. How did you learn about Partners in Learning, Inc? (Check All That Apply) PIL Website Web Search
 Friend/Family School District Conference Insurance Referral Fundraising Event Print Ad
Please provide detail for above choice: _____ Other _____