PARTNERS IN LEARNING, INC.

Teaching to the ♥ of What Matters Since 1999

Patient Information

Patient Name: ______________________________ Patient Date of Birth: ______________________________

Patient Address: ______________________________ Sex: ______________________________

______________________________ Home Phone: ______________________________

Mother/Guardian #1:

Name: ______________________________

Address if different: ______________________________

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Cell phone: ______________________________

Work phone: ______________________________

Email: ______________________________

Father/Guardian #2:

Name: ______________________________

Address if different: ______________________________

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Cell phone: ______________________________

Work phone: ______________________________

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 - If so, please provide name ______________________________ ☐ Other ______________________________