New Client Registration Form – For Evaluations

**** Today's Date:**

CLIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City_____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Sex: ○ M /○ F

Referring Physician /Other_____

PARENT/GUARDIAN INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

Email Address: _____ Sex: ○ M / ○ F

Home Phone #: Cell Phone #:

INSURANCE INFORMATION: (*Please list all insurance information even if ABA services are not covered under the plan)*
PRIMARY INSURANCE:
Plan Name: _____ Policy / ID#: _____

SECONDARY INSURANCE: ☐ √ If not applicable

Plan Name: _____ Policy / ID#: _____

ADDITIONAL INFORMATION:

- Current Diagnoses/Symptoms *(What brought you to us today?):* _____

  _____
- Currently receiving services (i.e. EI, SLP, OT, etc.)/Provider Name: _____
- For how long? _____
- Coordinator Contact Info: _____
- RITA-T and Bastille - Can we have a copy? ☐
- Do you consent to us reaching out to your EI for these documents? ☐ If yes send consent form to parent
- Any other testing received: _____
- Any additional information: _____

_____

_____

Please return form via email to: Rpaul@amegoinc.org or fax 508-455-6211

Questions: call 508-455-6405