Autism Spectrum Disorder Clinic Registration Form

Easter Seals Central Alabama

PATIENT INFORMATION

Child's name:_____
Last First Middle

Nickname _____ Male Female

Birthdate:_____ Age:_____ Race:_____ Social Security Number: _____

Address:_____

City, State, Zip: _____ County:_____

Referred By:_____

Why do you want your child evaluated? _____

_____

_____

Has your child had any previous testing?

- Psychological/Cognitive -Date: _____
- Academic- Date: _____
- Speech/Language- Date: _____
- OT - Date: _____
- Neurological Consult - Date: _____

Has your child ever received any type of therapy? (Speech, OT, PT, psychological)_____

Has your child seen a pediatrician in the last 12 months?_____ Date:_____
Has your child seen a developmental pediatrician?_____ Date:_____

PARENT/GUARDIAN/BILLING INFORMATION/RESPONSIBLE PARTY

Name_____
Last First Middle Nickname

Home Number:_____ Cell Number:_____ Work Number:_____

Mother Father Other Relationship (please specify):_____

Marital status: Married_____ Single_____ Divorced_____ Widowed _____
If yes, please give date If yes, please give date

Spouse's Name: _____

Home Number: _____ Cell Number: _____ Work Number: _____

**** * For the child to begin the scheduling process, all information above needs to be completed. Please include a copy of the front and back of parent/guardian's driver's license and insurance card or Medicaid card along with the $100 registration fee. Please mail registration form, registration fee, and copies to: Amy Berry; Easter Seals Central Alabama; 2125 E South Boulevard; Montgomery, AL 36116****