C.A.R.S.
THE CENTER FOR AUTISM AND RELATED SERVICES

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INTAKE FORM

(Please Type or Print)

Today's date:	Name of primary insurance:

PATIENT INFORMATION

Patient's last name: First: Middle:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:	Social Security no.:	Phone no.: ( )	
City:	State:	ZIP Code:	
Mother's last name: First:	Phone no.: ( )	Email:	
Father's last name: First:	Phone no.: ( )	Email:	

Chose agency because/Referred to clinic by (please check box): ❑ Dr. _____ ❑ Health Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other:

INSURANCE INFORMATION

(Please provide a copy of the patient's insurance card)

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:
Subscriber's address (if different):		Home phone no.: ( )	Cell phone no.: ( )	
Is patient covered by insurance? ❑ Yes ❑ No		Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		
Occupation:	Employer:	Employee benefits contact person:	Employer phone no.: ( )	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:	

ADDITIONAL INFORMATION

Name of referring physician:	Physicians address:	Physician's phone number ( )	
Diagnosis:	MM/YY of diagnosis:	Behavioral health case manager:	BH case manager phone no.:
Reason for referral:	☐ Challenging Behaviors ☐ Communication deficits ☐ Social Skills Training ☐ Other:	Has patient received ABA services before? If so, what are the dates of last ABA service?	☐ Yes ☐ No ___/___/___ - ___/___/___