EpicMinds Therapy

Basic Information

Patient Name (last, first): _____ Date of Birth: _____ (mm/dd/yy)

Gender: _____

Address: _____ City: _____ State: _____ Zipcode: _____

Primary Email: _____

Mother/Guardian (last, first): _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Father/Guardian (last, first): _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Primary language spoken in home: _____

Cultural/Religious Accommodations: _____

Physician Information

Did your child receive an ASD diagnosis? ____ yes ____ no

Do you have the diagnostic report? ____ yes ____ no

Who provided the Diagnosis? _____

Do you have referral for ABA services? _____ yes ____ no

Referring physician (last,first): _____ Phone: _____

Email: _____

Insurance Information

Primary Insurance: _____ Group #: _____

Subscriber ID #: _____ Subscriber Date of Birth: _____

Secondary Insurance: _____ Group #: _____

Subscriber ID #: _____ Subscriber Date of Birth: _____

Medication

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____