UW AUTISM CENTER
UNIVERSITY of WASHINGTON
Center on Human Development & Disability

Registration Form

Date Completed: ___ /___ / _____
Site Requested: ___ Seattle ___ Tacoma

Patient Information:

Name: _____ , _____, _____
Last First Middle

Date of Birth: ___/___/_____ Last Four Digits of SSN: _____ Gender: ☐ Female ☐ Male

Person Completing this Form:

If someone other than the client is filling out the form, please answer the following questions:

Name: _____ , _____ ___ Parent ___ Guardian ___ Other: _____
Last First

Are you authorized to consent for this individual's healthcare? ___ Yes ___ No

Contact Information:

Address: _____
Mobile Phone: _____ Home / Work Phone: _____ Email: _____

Insurance Information: Primary Insurance Coverage

Insurance Company Name _____ Name of Benefit Plan: _____

Subscriber Name: _____ , _____ DOB: ___/___/_____ SSN: ____-___-_____
Last First

Patient Relationship to Subscriber: ___ Self ___ Dependent ___ Spouse ____ Other: _____

ID #: _____ Group Number: _____ Provider Phone Number: _____

Insurance Address: _____

Insurance Information: Secondary Insurance Coverage

___ Client Does Not Have Secondary Coverage (if not, please skip this section)

Insurance Company Name: _____ Name of Benefit Plan: _____

Subscriber Name: _____ , _____ DOB: ___/___ /_____ SSN: ____-___-_____
Last First

Patient Relationship to Subscriber: ___ Self ___ Dependent ___ Spouse ____ Other: _____

ID #: _____ Group Number: _____ Provider Phone Number: _____

Insurance Address: _____

Guarantor:

Individual responsible for any expenses not covered by insurance

Name: _____ , _____ Relationship to Client: _____ Phone: _____
Last First

Address: (___ Same as Above)_____

[autofill patient's last name]
[autofill patient's DOB]

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Legal Next of Kin:

Individual can make decisions for client in an emergency

Name: _____ , _____ Relationship to Client: _____ Phone: _____
Last First

Primary Healthcare Provider:

Primary Care Physician: _____ Clinic/Hospital: _____

Phone Number: _____ Address: _____

Household and Family Information:

Patient's Relationship Status: ____ Single ____ Married ___ Divorced/ Separated ___ Other: _____

If living with parents, are parents divorced or separated? ___ Yes ___ No
If Yes, please indicate the type of custody: ___ Joint ___ Sole Name: _____
Who is responsible for medical decisions regarding the client: _____

Primary Language Spoken in the Home: _____ Other Languages Spoken: _____

Services Being Pursued:

Please indicate which service(s) you are interested in pursuing at the UW Autism Center:

___ Diagnostic Evaluation ___ Re-evaluation ___ Medical Consultation ___ Sleep Consult Clinic

___ Infant Clinic ___ Speech Therapy ___ Social Skills Group ___ Psychological Therapy

___ ABA Therapy: (choose one or more)

Intensive in-Home Program Parent Coaching, Client Focused Skills Coaching

Short-Term Consultation

Additional Questions and Comments:

Who referred you for services? _____
What are some of your concerns or the referral sources concerns regarding the client?

_____

_____

_____

Additional Comments (optional):

_____

_____

_____

[autofill patient's last name]
[autofill patient's DOB]