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

**Ethnicity:** ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other _____

## 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: _____

*Is it OK to leave a message that may include confidential or personal health care information at a phone number and/or email? Yes No If Yes- please specify the phone number here:* _____

***Please note that we cannot guarantee the confidentiality of the messages. They are not secure through email or voicemail.***

## 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

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)_____

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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:

___ Autism Evaluation ___Re-evaluation ___Medical Consultation ___Sleep Consult Clinic

___ Infant Clinic ___ Speech Therapy ___Social Skills Group ___Psychological Therapy

___ ABA Therapy: (check 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?

_____

Has patient been diagnosed with Autism? ___Yes if yes, when and by whom? _____

_____

_____

What are some of your concerns or the referral sources concerns regarding the client?

_____

_____

_____

Additional Comments (optional):

_____