ABA Tree
142 Beach 120th Street
Rockaway Park, NY 11694
Phone: (347) 674-8733
Fax: (718) 634-5429

Date Form is Completed:	
Client Name:	Gender:
Age:	DOB:
Diagnosis Code:	Language(s):
Parent/Guardian Name(s):	Email:
Phone: (Home)	(Cell)
Address:	Ok to Leave Message?
Emergency Contact:	Relation to Client:
Emergency Contact Phone:	

School Name:
Address:
Phone Number:
Name of Referring Doctor:
Medications:
Allergies:

Insurance Information: Please include copy (front and back) of insurance card	
Primary Insurance:	
Insurance Co:	Number:
Subscriber Name:	Sub. DOB:
Secondary Insurance:	
Insurance Co:	Number:
Subscriber Name:	Sub. DOB:

By signing below, I _____, attest that _____
(parent/guardian) (client)

does not have any other insurance coverage then those listed above.

_____ _____
(signed name) (date)

Presenting Problems/Behaviors/Communication Deficits/Delays: _____

_____

_____

_____

Please list days/hours available for therapy and total # of hours desired: _____

_____

_____