ATC
Autism Treatment Center
Newtown Square

PATIENT INFORMATION

Please PRINT or ask to have this form filled out for you

Patient Name_____**Date**_____

Parent's Names:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: M__ F__ Birth date: ___/___/_____ SS# (last 4): _____

Email**:** _____

GUARANTOR: (Responsible Party If Not You)
Name: (please print) _____

Address: _____

City: _____State: _____Zip Code: _____

Sex: M____F____ Birth date: ____/____/_____ Relationship to patient: _____

PRIMARY CARE PHYSICAN:
Name: _____

Practice Name/Address:_____

Telephone: (____) _____

May we contact regarding your progress? ( ) Yes ( ) No Initial: _____

EMERGENCY CONTACT:
Name: _____

Address:_____

Telephone: (____) _____ Relationship: _____

REFERRAL SOURCE: Please **circle**

PHYSICIAN: _____ **FRIEND/RELATIVE:** _____

OTHER: _____**PLEASE NAME THE SOURCE:**
(IE: TELEVISION – INTERNET – EMPLOYEE – NEWSPAPER – MAGAZINE)