Children's Autism Treatment Specialists, LLC.
Preserve Plaza
18070 S. Tamiami Trail, Unit 16
Fort Myers, FL 33908
(239) 985-CATS (2287)
fax (239) 481-2287
catsautismcenter@gmail.com

SOCIAL SKILLS REGISTRATION FORM

CLIENT INFORMATION

CLIENT NAME: _____ SEX: (M F) DOB: _____-_____-_____
LAST FIRST M.I. MO DAY YR
ADDRESS_____CITY: _____STATE: _____ ZIP: _____

HOME PHONE: _____SS#:_____-_____-_____PATIENT #:(OFFICE USE)_____
HOW DID YOU HEAR ABOUT US? Phonebook ____ Website ____ Friend ____ Doctor ____ Other _____

RESPONSIBLE PARTIES (PARENT/LEGAL GUARDIAN)

NAME: _____
LAST FIRST M.I.
ADDRESS:_____CITY: _____STATE: _____ ZIP: _____

RELATION TO CLIENT:_____ EMAIL ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____CELL PHONE: _____

NAME: _____
LAST FIRST M.I.
ADDRESS:_____CITY: _____STATE: _____ ZIP: _____

RELATION TO CLIENT:_____ EMAIL ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____CELL PHONE: _____

INSURANCE (If Applicable)

PRIMARY INSURANCE CO.: _____POLICY NUMBERS: _____
(ID#) (GROUP/PLAN#)
POLICY HOLDER: _____EMPLOYER: _____
LAST FIRST M.I.
DATE OF BIRTH: _____-_____-_____ SS#: _____-_____-_____RELATION TO CLIENT: _____
MO DAY YR

INSURANCE CO. PHONE: _____

SIGNATURE: _____ DATE: _____
Parent/Legal Guardian