Southlake Autism and Behavior Services
355 Citrus Tower Blvd, Suite 116
Clermont, FL 34711
Phone: 352.223.1999 ʘ Fax: 352.600.3119

Patient Name (Last, First)	Age	Birth Date	Sex

Mailing Address	City	State	Zip Code	Marital Status

Primary Diagnosis	Primary Numeric Diagnosis	Secondary Numeric Diagnosis

Insured Parent's Information

Name (Last, First)	Age	Birth Date	Sex	Relationship to Patient

Address (put same if same as above)	City	State	Zip Code	Marital Status

E-Mail Address	Home Phone	Cell Phone

Pediatrician

Name (Last, First)	Phone	Fax

Primary Insurance Information

Primary Insurance Company	Policy Holder Name		Date of Birth	Policy Number
Insurance Address	City	State	Zip Code	Group Number
Phone Number	**Co-Insurance % Office Use Only**		**Co-Pay Office Use Only**	**Deductible Office Use Only**

Secondary Insurance Information (If Applicable)

Secondary Insurance Company	Policy Holder Name		Date of Birth	Policy Number
Insurance Address	City	State	Zip Code	Group Number
Phone Number	**Co-Insurance % Office Use Only**		**Co-Pay Office Use Only**	**Deductible Office Use Only**

Patient Release

I verify the information I have provided is correct and authorize the release of medical information necessary to process insurance claims to insurance companies and their agencies, for the purpose of filing and payments of medical claims. I also authorize payment of the medical benefits to the provider, Southlake Autism and Behavior Services, PA. I acknowledge a fee at the provider's current rate may be charged on all "past due" balances.

Signature of insured or authorized person, parent	Date Signed

Form E