Sycamore Services, Inc.
ABA Opportunity Center

New ABA Client Basic Intake Information

Name:		Date Completed:
DOB:	Sex: male ☐ female ☐	SSN:

Parent/Guardian Name:		Relationship to Child
Address:		
City:	State:	Zip Code:
Phone #:	Email Address:	
Preferred Method of Contact:		Can we leave a voicemail at this number? YES ☐ NO ☐

Parent/Guardian Name:		Relationship to Child
Address: (if different than above)		
City:	State:	Zip Code:
Phone #:	Email Address:	
Preferred Method of Contact:		Can we leave a voicemail at this number? YES ☐ NO ☐

Primary Care Physician:	Phone #:
Address:	

Referred By: ☐ Self-Referred ☐ Professional (doctor, first steps, etc.) ☐ other
Name of Referral Source, Professional, or Organization:
Has your child received a diagnosis of autism spectrum disorder? ** ☐ YES ☐ NO
Date of Diagnosis: Diagnosing Physician:
Is your Child currently signed up for the Medicaid Waiver? ☐ YES ☐ NO ☐ ON WAITING LIST

If YES, please include a copy of the Dx report

Primary Insurance Information	
Insurance Company:	Policy #:
Name of Insured:	Relationship to Child:
Insured's DOB:	Insured's SSN:
Group Name:	Group #:
Insured's Address (if different than above)	

Secondary Insurance Information	
Insurance Company:	Policy #:
Name of Insured:	Relationship to Child:

Insured's DOB:	Insured's SSN:
Group Name:	Group #:
Insured's Address (if different than above)	

In a few words, tell us why you are seeking ABA services and about your primary concerns for your child:

Please email the completed form to ABAintake@sycamoreservices.com

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