Comprehensive Autism Partnership

New Patient Information

Child's Name: _____

Parent Name's: _____

DOB: _____ Phone: _____

Address: _____

_____

Email: _____ IEP (yes or no): _____

Primary Insurance Name: _____

Primary Insurance ID Number: _____

Secondary Insurance Name: _____

Secondary Insurance ID Number: _____

Referring Physician Name, Phone, & Fax: _____

_____

For Tricare - Enrolled in ECHO (yes or no): _____

Other: _____

_____

_____

Please submit via email to: Insurance@capaba.com or via fax (775) 392-1245