Gulf Coast Education Solutions, LLC
Specialized Services for Exceptional Learners!

23272 Hwy 49 Frontage Rd. Ste C
Saucier, MS 39574
(228) 806-0616
www.gulfcoastedsolutions.com

Insurance Information Form

Client Information:

Last Name: _____ First Name: _____ MI: _____DOB: _____ SEX: M F

SSN: _____ Address:_____ Apt# _____

City: _____ State: _____ Zip: _____ Mother's Name: _____

Phone Number: _____ Employer: _____City: _____

State: _____ Zip: _____ Work# _____ Father's Name: _____

Phone Number: _____ Employer: _____ City: _____

State: _____ Zip: _____ Work# _____

Insurance Information: We will need a copy of insurance card(s)

Primary Insurance: _____ Policy/Sponsor# _____ Group#/ID _____

Effective Date: _____ Insured's Name: _____ DOB: _____

SSN: _____ Insured's Address: _____ Apt# _____ City: _____

State: _____ Zip: _____

Secondary Insurance: _____ Policy/Sponsor# _____ Group#/ID _____

Effective Date: _____ Insured's Name: _____ DOB: _____

SSN: _____ Insured's Address: _____ Apt# _____ City: _____

State: _____ Zip: _____

Responsible Party:

Person Responsible for Payment: _____ Phone# _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

To the best of my knowledge, all of the above information is true and complete. I understand that I am responsible to pay for all services rendered to me, and I am willing to make specific arrangements to pay whatever part is not covered by insurance on a timely basis. (**PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSIUNG THE CLIENT FOR FEES PAID TO THE PROVIDER AND IS NOT A SUBSTITUTE FOR PAYMENT.) IN ORDER TO MONITOR YOUR COST OF BULLINGS, WE REQUEST THAT OUR CHARGES FOR SERVICES BE PAID ON THE DAY SERVICES ARE GIVEN OR THE FIRST MONDAY OF EACH MONTH.**

I authorize payment of benefits from my insurance be paid directly to the Provider. I also authorize the Provider to release my billing service and insurance company any and all information necessary for the processing of insurance claims.

Client/ Legal Guardian Signature: _____ _____

Date

Print Name: _____

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Intake Application for Services

Child Name: _____ D.O.B. _____

Address: _____ Age/Grade: _____

_____ SSN: _____
(Only if filing insurance)

Parent/Guardian: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Preferred method of contact: ☐ Phone/Voicemail ☐ Text ☐ Email ☐ Facebook Messenger

How did you hear about us? _____

What types of service(s) are you interested in? _____

Has your child had an evaluation for any type of disability? _____ If yes, date? _____

Evaluator: _____ List results of the evaluation: _____

_____

Does your child need an evaluation? _____ If yes, list evaluation needed or suspected area of disability/impairment: _____

Describe problems observed: _____

Is your child in ☐ public school ☐ private school ☐ homeschool ☐ out of school

If homeschooling, what program do you use? _____

Is there any instruction that has worked well? _____

Not worked? _____

Special Interests? _____

Any health concerns (physical, mental, emotional)? _____

_____

Is there any additional information you would like to share that would help us in determining the most appropriate services for your child?_____

_____

_____

_____

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Service History

Has your child previously received special services? _____ If yes, describe: _____

_____

Service Provider/Organization: _____ Dates: _____ to _____

May we obtain records from this provider? Y / N (If yes, please sign Consent to Release Information)

Did any problems arise during these services? Y / N

If yes, describe: _____

_____

What worked best during these services (anything you would like us to continue)?

_____

_____

DEVELOPMENTAL HISTORY

PERSONAL INFORMATION

Child's Name: _____ DOB: _____ Grade: _____ Age: _____

Race/Ethnicity: _____ Gender: Male/ Female

HOME AND FAMILY INFORMATION

Parent(s)/Guardian(s): _____

Home Address: _____ Home Phone: _____

Employer/Occupation: _____ Work Phone: _____

Child lives with: _____ Relationship to child: _____

List all persons living in the home:

Name	Age	Gender	Relationship	Any special needs?
1.				Y / N
2.				Y / N
3.				Y / N

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4.				Y / N
5.				Y / N

Describe any major life event or changes in the family situation that may have affected your child (e.g. abuse, accident, change in guardianship, death, divorce, economic hardship, remarriage, etc.)_____

_____

_____

FAMILY EDUCATIONAL HISTORY

Is there a history of reading/spelling difficulties in your family? Y / N

Are there any official diagnosis of dyslexia? Y / N

If yes, describe and list relationship of individual:

_____

_____

_____

_____

LANGUAGE(S)

What is the primary language spoken in the home? English / Spanish / Other: _____

Are there any other languages in the home: Y / N If yes, please describe each language in the home: None/ Little/ Fluent

Language	Child		Parent(s)/ Guardian(s)	
	Speaks	Understands	Speaks	Understands
English				

STRENGTHS/WEAKNESSES

Describe your child's strengths: _____

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Describe your concerns in your child's development, behavior, or learning: _____

MEDICAL/PHYSICAL DEVELOPMENT

Birth History

Mother's age at birth:_____ years | **Mother received prenatal care during pregnancy?** ☐ Yes ☐ No

Were there any complications during pregnancy or delivery? ☐ Yes ☐ No (skip to next question)
☐ High blood pressure/toxemia ☐ Maternal injury/illness ☐ Exposure to alcohol/cigarettes /drugs
☐ Rubella/German measles ☐ Gestational diabetes ☐ Emergency C-section
☐ Premature (___ weeks gestation) ☐ Low birth weight (indicate one: ☐ <2.3 lbs. ☐ 2.3-3.3lbs ☐ 3.4-5.4 lbs.)
☐ Other: _____

Did your child have an extended stay in the hospital after birth? ☐ Yes ☐ No (skip to next question)
Length of time: ☐ < one week ☐ one to four weeks ☐ one month or more (___ months)
Reason: _____

General Health

Has your child been hospitalized or had any significant operations? ☐ Yes ☐ No (skip to next question)
Explain: _____

Has your child had any significant medical conditions or illnesses? ☐ Yes ☐ No (skip to next question)
☐ Eye or vision problems ☐ Heart problems ☐ Hydrocephalus, hemorrhages, and/or shunt
☐ Ear infections and/or ear tubes ☐ Seizures/neurological issues ☐ Allergies (specify:_____)
☐ Asthma or breathing difficulties ☐ Significant infections (e.g., meningitis, encephalitis, etc.) or high fevers
☐ Other: _____

_____
_____

Has your child had any significant accidents/injuries (e.g., head injuries)? ☐ Yes ☐ No (skip to next question)
☐ Motor vehicle accident(s) ☐ Fall-related injury(ies) ☐ Significant blow(s) to the head
☐ Other: _____
Explain: _____

Has your child had any difficulties or disorders with the following? ☐ Yes ☐ No (skip to next question)
☐ Eating difficulties/disorders ☐ Sleeping difficulties/disorders ☐ Toileting difficulties/disorders
Explain: _____

Is your child currently being treated for a medical condition? ☐ Yes ☐ No (skip to next question)
Does your child have a regular healthcare provider/medical home? ☐ Yes ☐ No
When was your child's last visit to a healthcare provider? Indicate one: ☐ <6 months ☐ 6-12 months ☐ >1 year
May we access your child's medical records? ☐ Yes (please complete a release form) ☐ No
Is your child currently taking any medications? ☐ Yes ☐ No
Explain: _____

Has your child ever received speech, physical, or occupational therapy? ☐ Yes ☐ No (skip to next question)
Explain: _____

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Hearing and Vision

Has your child ever had his/her hearing and/or vision tested? ☐ Yes ☐ No (skip to next question)
☐ Hearing only ☐ Vision only ☐ Hearing and vision
Hearing results: _____
Vision results: _____

Does your child require devices to assist with hearing or vision? ☐ Yes ☐ No (skip to next question)
☐ Hearing aids (when acquired:_____) ☐ Glasses (when acquired:_____)

MOTOR DEVELOPMENT

Describe any concerns you have about your child's gross motor skills (e.g., walking, hopping, jumping, running, climbing stairs, kicking balls, etc.).

Describe any concerns you have about your child's fine motor skills (e.g., writing or coloring, working buttons/zippers, tying shoes, cutting, etc.).

Describe any additional concerns you have about your child's physical development.

EDUCATIONAL BACKGROUND

Has your child ever attended a preschool program or childcare center? ☐ Yes ☐ No (skip to next question)
Name: _____ Phone: _____
Address: _____ Teacher: _____

Describe any difficulties your child has had with learning activities.

Has your child ever been evaluated/assessed/tested for learning difficulties? ☐ Yes ☐ No (skip to next section)
By whom: _____ When: _____
Results: _____
_____

COGNITIVE / ADAPTIVE DEVELOPMENT

Can your child follow directions? ☐ Yes ☐ No (skip to next question)
☐ One-step directions only ☐ Two-step directions ☐ Multi-step directions

Does your child know any of the following information about him/herself?
☐ Name ☐ Age ☐ Gender
☐ Parent(s) name(s) ☐ Address ☐ Home phone number

Does your child:
☐ Identify parts of the body ☐ Identify colors ☐ Count (highest number: _____)
☐ Identify letters of the alphabet ☐ Play with building toys/puzzles ☐ Identify size (e.g., big, little, tall, short, etc.)
☐ Looks at books independently ☐ Enjoy being read to ☐ Identify shapes (e.g., circle, square, etc.)
☐ Recognize written words ☐ Read books independently ☐ Identify money (e.g., dime, quarter, dollar)

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Does your child independently:

☐ Drink from a cup without spilling	☐ Dress self completely	☐ Use toilet without accidents during day
☐ Eat with a spoon and fork	☐ Put shoes on correct feet	☐ Use toilet without accidents during night
☐ Brush hair and teeth	☐ Put on a coat/jacket	☐ Clean table/space after eating/activity
☐ Bathe self	☐ Make up bed	☐ Cross the street safely

Describe any additional concerns you have about your child's thinking or daily living skills.

COMMUNICATION DEVELOPMENT

Does your child seem to understand what is said to her/him? ☐ Yes (skip to next question) ☐ No
Explain:

How does your child communicate?

☐ Gestures only	☐ Gestures and some speech	☐ Primarily speech with some gestures

Does your child…

☐ Make up stories/songs	☐ Talk about daily activities	☐ Use "*me*," "*you*," plurals, and past tense

Who can understand what your child says? (check all that apply)

☐ Family/caregivers	☐ Other children	☐ Unfamiliar adults

Describe any additional concerns you have about your child's language or speech skills.