**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_’s Service Providers**

|  |  |
| --- | --- |
| **Primary Physician**Name:Clinic:Address:Phone/Fax: | **Hospitalizations:**Dates:Location:Phone/Fax:Dates:Location:Phone/Fax: |
| **Dentist**Name:Office Name:Address:Phone/Fax: |
| **Psychiatrist**Name:Office Name:Address:Phone/Fax: | **Day/Residential Treatment Facilities**Dates:Facility Name:Contact Person:Address:Phone/Fax:Dates:Facility Name:Contact Person:Address:Phone/Fax: |
| **Therapist**Name:Office Name:Address:Phone/Fax: |
| **County Case Manager**Name:Address:Phone/Fax: | **School**School Name:Address:Phone/Fax: |
| **People Who Have Permission For Contact:** | **Evaluations**Location:Address:Phone/Fax: |
| **No Contact List:** | **Other** |
| **Insurance Information**Name:ID Number:Policy/Group Number:Phone/Fax: | **Insurance Contacts:**Name:Title”Phone/Fax: |