**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_’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: |