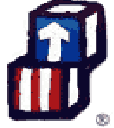
Community Services
CSNT
of Northeast Texas, Inc.

Head Start

"Building partnerships, changing lives"



Child Health Form
Medical / Dental Home

Child's Name: ___________________________ D.O.B. __________

Medical insurance Providers

Insurance Type:

_______ CHIPS
_______ Medicaid
_______ Private: __________________________________
_______ Other (TriCare)
_______ No Coverage

Policy Number: ________________________________
Insurance Effective Date: ________________________
Primary Insurance: _______ Yes ________No
Dental Included: _______ Yes ________No

Current Medical Provider: __________________________________
Phone: __________________________________
Current Dental Provider: __________________________________
Phone: __________________________________

Hospital to use in case of an emergency:
____

	Disability	Suspected	Identified
	Autism		
	Emotional/Behavior		
	Hearing Impairment		
	Learning Disability		
	IDD		
	Orthopedic Impairment		
	Vision Impairment		
	Speech or Language		
	Traumatic brain Injury		