Child Health Form
Medical / Dental Home

Child's Name: _____

Insurance Type:

_____ CHIPS
_____ Medicaid
_____ Private: _____
_____ Other (TriCare)
_____ No Coverage

Policy Number: _____
Dental Included: _____ Yes _____No

Current Medical Provider: _____
Phone: _____
_____ None at this time

Current Dental Provider: _____
Phone: _____
_____None at this time

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		