MEDICAL, DENTAL AND THERAPYAPPOINTMENTS

MONTHLY REPORT

MUST BE **RECEIVED** IN THE OFFICE **BEFORE** THE **5TH** OF EACH MONTH

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CHILDS NAME **(above)** Month / Year

MEDICAL AND DENTAL INFORMATION

(Please list **ALL** appointments and specify whether they are dental, medical, or vision.)

Please Have a "HEALTH PROVIDER CONTACT FORM" Filled Out For Each Visit

Date	Name of Doctor/Dentist/Medical Center ***very important***	Reason for visit	Follow-up yes/no

*Please remember that **ALL** **H**ealth **P**rovider **C**ontact **Forms** **MUST** be filled out and Signed by the Provider of Services.*

COUNSELING INFO

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THERAPIST NAME **(please write above)**

Counseling Dates This Month (mm/dd/yy)

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