Medical / Dental
Community Health Care Providers

☼ Primary / Community Care Provider: _____
Date of First Visit: _____
Office Nurse/Medical Assistant: _____
Address: _____
_____
Phone: _____ Fax: _____ E-Mail: _____

☼ Primary Children's Medical Center
Medical Record Number: _____
Address: _____
_____
Phone: _____ Fax: _____

☼ Community or Specialty Hospital: _____
Medical Record Number: _____
Address: _____
_____
Phone: _____ Fax: _____

☼ Community Specialty Care Provider: _____
Specialty: _____Date of First Visit: _____
Office Nurse/Medical Assistant: _____
Address: _____
Phone: _____ Fax: _____ E-Mail: _____

☼ Community Specialty Care Provider: _____
Specialty: _____Date of First Visit: _____
Office Nurse/Medical Assistant: _____
Address: _____
Phone: _____ Fax: _____ E-Mail: _____

☼ Dental Provider: _____
Date of First Visit: _____
Address: _____
Phone: _____ Fax: _____ E-Mail: _____

☼ Orthodontist: _____
Date of First Visit: _____
Address: _____
Phone: _____ Fax: _____ E-Mail: _____

There is space to list more Specialty Care Providers on the next page.

(Adapted from the Care Notebook with permission, Children's Hospital and Regional Medical Center, Seattle, WA, 2003.)
Utah Department of Health, c. 2005.

Providers (Continued)

Many specialty physicians may treat your child. You may keep track of some them here:

☼ Community Specialty Care Provider: ______________________________
Specialty: ______________ Date of First Visit: ______________________
Office Nurse/Medical Assistant: __________________________________
Address: ____
Phone: ____________ Fax: ______________ E-Mail: _______________

☼ Community Specialty Care Provider: ______________________________
Specialty: ______________ Date of First Visit: ______________________
Office Nurse/Medical Assistant: __________________________________
Address: ____
Phone: ____________ Fax: ______________ E-Mail: _______________

☼ Community Specialty Care Provider: ______________________________
Specialty: ______________ Date of First Visit: ______________________
Office Nurse/Medical Assistant: __________________________________
Address: ____
Phone: ____________ Fax: ______________ E-Mail: _______________

☼ Community Specialty Care Provider: ______________________________
Specialty: ______________ Date of First Visit: ______________________
Office Nurse/Medical Assistant: __________________________________
Address: ____
Phone: ____________ Fax: ______________ E-Mail: _______________

☼ Community Specialty Care Provider: ______________________________
Specialty: ______________ Date of First Visit: ______________________
Office Nurse/Medical Assistant: __________________________________
Address: ____
Phone: ____________ Fax: ______________ E-Mail: _______________

☼ Community Specialty Care Provider: ______________________________
Specialty: ______________ Date of First Visit: ______________________
Office Nurse/Medical Assistant: __________________________________
Address: ____
Phone: ____________ Fax: ______________ E-Mail: _______________