Orange County Head Start, Inc.

REQUIRED ORAL EXAMINATION FORM

PATIENT INFORMATION

Child's Name _____ Date of Birth _____ Phone Number _____

Parent/Guardian Name _____ Address _____

EXCHANGE OF INFORMATION/INTERCAMBIO DE INFORMACIÓN

As the parent of the child referenced above, I hereby authorize the release of the information contained in this document to be provided to Orange County Head Start, Inc.

Como el padre/tutor del niño identificado en este formulario, yo autorizo el intercambio de información médica que se encuentra en este documento a Orange County Head Start, Inc.

Parent Signature/*Firma de Padre* _____ Date/*Fecha* _____

ORAL HEALTH CARE SERVICES DELIVERED DURING VISIT

Diagnostic/Preventative Services

Examination:	☐ Yes	☐ No
X-Rays:	☐ Yes	☐ No
Risk Assessment:	☐ Yes	☐ No
Cleaning:	☐ Yes	☐ No
Fluoride Varnish:	☐ Yes	☐ No
Dental Sealants:	☐ Yes	☐ No

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____

_____

(Please specify specialist)

Restorative/Emergency Care

Fillings:	☐ Yes	☐ No
Crowns:	☐ Yes	☐ No
Extractions:	☐ Yes	☐ No
Emergency Care:	☐ Yes	☐ No

Other: _____

_____

(Please specify)

TREATMENT STATUS

All Treatment Completed: ☐ Yes ☐ No **or** ☐ No Treatment Needed

More appointments need for treatment? ☐ No ☐ Yes → **If Yes:** Please indicate next appointment date: _____

FOLLOW-UP STATUS OF DENTAL TREATMENT

Follow-Up Treatment Date: _____ **All Treatment Completed:** Yes ☐ No ☐

Staff Initials: _____ Date: _____

Follow-Up Treatment Date: _____ **All Treatment Completed:** Yes No

Staff Initials: _____ Date: _____

HEAD START STAFF ONLY	PROVIDER USE ONY	
Date Received (Stamp):	**Office Stamp:**	**EXAM DATE:** **Provider Name:** **Phone/Fax:** **Signature:**