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

EXAM DATE: _____

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

RECALL APPT: _____

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:	Provider Name:
		Phone
		Fax:
		Signature: