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.

Là Phụ huynh của con tôi sau đây. Tôi bằng lòng cung cấp những thông tin sức khoẻ trong văn bản này cho cơ quan Quận Cam Head Start, Inc.

Parent Signature/ *Phụ Huynh Ký tên* ____________ Date/ *Ngày* ____________

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: