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.

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: