



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

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)

RECALL APPT: _____

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

Date Received (Stamp): _____

PROVIDER USE ONLY

Office Stamp:	Provider Name:
	Phone
	Fax:
	Signature: