



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 khỏe 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

- Counseling/Anticipatory Guidance**
- Yes No
- Referral to Specialty Care**
- Yes No
- _____
- _____

- Restorative/Emergency Care**
- Fillings: Yes No
 - Crowns: Yes No
 - Extractions: Yes No
 - Emergency Care: Yes No
 - Other: _____

RECALL APPT: _____

(Please specify specialist)

(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

Date Received (Stamp): _____

PROVIDER USE ONLY

Office Stamp:	Provider Name:
	Phone:
	Fax:
	Signature: