Orange County Head Start, Inc.
Empowering Children & Families

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

NEXT APPT: _____

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____

_____

(Please specify specialist)

Dental Diagnosis *(check all that apply)*

- ☐ Normal Examination/No treatment needed
- ☐ Restorative Dental Treatment Needed:
  - ☐ Fillings
  - ☐ Crowns
  - ☐ Extractions
  - ☐ Emergency Care
  - ☐ Other: _____

TREATMENT STATUS

Check all that apply

- ☐ Dental Treatment Completed
- ☐ Dental Treatment Initiated
- ☐ Date of next treatment appt: _____

FOLLOW-UP STATUS OF DENTAL TREATMENT

Follow-Up Treatment Date: _____

- ☐ Dental Treatment Completed
- ☐ Date of next treatment appt: _____

Staff Initials: _____ Date: _____

Follow-Up Treatment Date: _____

- ☐ Dental Treatment Completed
- ☐ Date of next treatment appt: _____

Staff Initials: _____ Date: _____

HEAD START STAFF ONLY	PROVIDER USE ONLY	
Date Received (Stamp):	Office Stamp:	Provider Name:
		Phone:
		Fax:
		Signature: