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/TRAO ĐỔI THÔNG TIN

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 nêu trên, tôi bằng lòng cung cấp những thông tin sức khoẻ trong văn bản này cho Orange County 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

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
Date Received (Stamp):

PROVIDER USE ONLY	
Office Stamp:	Provider Name:
	Phone:
	Fax:
	Signature: