

### 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)*

##### Dental Diagnosis *(check all that apply)*

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

**NEXT APPT:** \_\_\_\_\_

#### 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: