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