Orange County Head Start, Inc.
Empowering Children & Families

# DENTAL EXAMINATION FORM

## PATIENT INFORMATION

Participant's Name ______________________ Date of Birth ______________

## EXCHANGE OF INFORMATION/INTERCAMBIO DE INFORMACIÓN

I hereby authorize the release of the information contained in this document to be provided to Orange County Head Start, Inc.
*Yo autorizo el intercambio de información médica que se encuentra en este documento a Orange County Head Start, Inc.*
*Tôi bằng lòng cung cấp những thông tin sức khoẻ trong văn bản này cho cơ quan Quận Cam Head Start, Inc.*

Signature/*Firma/Ký tên* ______________________ Date/*Fecha/Ngày* ______________

**DATE OF EXAM: ________________**

### Services Provided

| | | |
|---|---|---|
| Examination: | ☐Yes | ☐No |
| X-Rays: | ☐Yes | ☐No |
| Risk Assessment: | ☐Yes | ☐No |
| Cleaning: | ☐Yes | ☐No |
| Fluoride Varnish: | ☐Yes | ☐No |
| Dental Sealants: | ☐Yes | ☐No |
| Anticipatory Guidance | ☐Yes | ☐No |

**RECALL APPOINTMENT DATE:** ________________

### Dental Diagnosis

☐Normal Examination/No treatment needed
☐Restorative Dental Treatment Needed

**Mark each applicable box**

- ☐Fillings
- ☐Crowns
- ☐Extractions
- ☐Emergency Care
- ☐Other: ________________
- ☐Referral to Specialty Care

________________________________
*(Please specify specialist)*

**Comments:**

________________________________
________________________________
________________________________

### Treatment Status *(If applicable)*

Did the child receive needed dental treatment?
☐Yes ☐No

Is additional treatment needed?
☐Yes: ________________ ☐No
*Appointment Date*

| HEAD START STAFF ONLY |
|---|
| Date Received (Stamp): |

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