Klamath Family Head Start 1940 S. Sixth St. Klamath Falls, OR 97601
541 882-5988 Fax: 541 884-2803

Oral Exam

Date of Exam:_______________ Class #____________

Child's Name:_______________________________________ Date of Birth:________________
(Or name of participant)
____ Check here if participant is a pregnant mother

Results:
___ No treatment needed (up to date with care)
___ Treatment needed
___ Treatment in progress
___ Treatment complete

Next scheduled appointment:
____
Date treatment will be complete:
____

Treatment urgency:
___ No obvious problems
___ Early dental care needed
___ Urgent dental care needed

____Yes ____No Participant has cavities
____Yes ____No Participant has treated decay fillings
____Yes ____No Participant has had ECC (current or past decay in upper anterior teeth)
____Yes ____No Participant has gum disease
____Yes ____No Participant received fluoride
____Yes ____No Participant received cleaning

Comments:
____
____
____

Name of Provider/Office:_____________________________ Date completed:_____________
Address:_____________________________ Phone:_____________________

Signature of Provider:____