

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

**PRIVATE DENTIST REPORT OF
DENTAL EXAMINATION OF A PUPIL OF
SCHOOL AGE**

NAME OF SCHOOL _____ DATE _____ 20 _____

NAME OF CHILD			AGE	SEX	GRADE	SECTION/ROOM
Last	First	Middle		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS _____

No. and Street	City or Post Office	Borough or Township	County	State	Zip
----------------	---------------------	---------------------	--------	-------	-----

REPORT OF EXAMINATION

	TOOTH CHART																
	RIGHT								LEFT								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
	UPPER																Upper
	LOWER																Lower

Is The Child Under Treatment Yes No

Treatment Completed Yes No

Date of Dental Examination

Signature of Dental/Examiner

Print Name of Dental Examiner

Address