

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/Township County State Zip

REPORT OF EXAMINATION

| | TOOTH CHART | | | | | | | | | | | | | | | | |
|-------|-------------|----|----|---|---|---|---|---|------|----|----|----|----|----|----|----|-------|
| | RIGHT | | | | | | | | LEFT | | | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | |
| UPPER | | | | A | B | C | D | E | F | G | H | I | J | | | | Upper |
| LOWER | 32 | 31 | 30 | T | S | R | Q | P | O | N | M | L | K | | | | 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