

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
<div style="display: flex; justify-content: space-between; font-size: small;"> Last First Middle </div>		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS _____

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