

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											
UPPER		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	K	L	M	N	O	P	Q	R	S	T
LOWER		32	31	30	29	28	27	26	25	24	23	22	21	20	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