

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	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

