

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 \_\_\_\_\_

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