

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
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Last	First	Middle		M	F		

ADDRESS _____

No. and Street City or Post Office Borough or 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
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