

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 or Township	County	State	Zip
----------------	---------------------	---------------------	--------	-------	-----

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