

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
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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	K	L	M	N	O	Upper
LOWER		32	31	30	T	S	R	Q	P	O	N	M	L	K	J	I	H	G	F	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