

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								
UPPER	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				
LOWER	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	Lower
				T	S	R	Q	P	O	N	M	L	K				
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