

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	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