

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 ☐ M ☐ F	GRADE	SECTION/ROOM
Last	First	Middle				

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								
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