

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HEALTH

**PRIVATE DENTIST REPORT**  
**OF DENTAL EXAMINATION/SCREENING OF A PUPIL OF SCHOOL AGE**

NAME OF SCHOOL \_\_\_\_\_ DATE \_\_\_\_\_ 20\_\_

<u>NAME OF STUDENT</u>	<u>DATE OF BIRTH</u>	<u>GRADE</u>	<u>SECTION/ROOM</u>
_____ Last                      First                      Middle	_____	_____	_____

ADDRESS

\_\_\_\_\_

No. and Street                      City or Post Office                      Borough/Township                      County                      State                      Zip

\_\_\_\_\_

**REPORT OF EXAMINATION/SCREENING**

		<b><u>TOOTH CHART</u></b>																
		<b><u>RIGHT</u></b>								<b><u>LEFT</u></b>								
<u>UPPER</u>		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
<u>LOWER</u>		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
<u>EXAM</u>	<u>UPPER</u>																	Upper
	<u>LOWER</u>																	Lower

Untreated Decay: \_\_\_\_\_ No    Yes

Treated Decay: \_\_\_\_\_ No    Yes

Sealants on Permanent Molars    No    Yes

Treatment Urgency: \_\_\_\_\_ None    Early    Urgent

\_\_\_\_\_ Date

Signature of Dental Provider                      Print Name of Dental Provider

\_\_\_\_\_ Address of Dental Provider