## COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HEALTH

## PRIVATE DENTIST REPORT OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

Last   First   Middle   M   F	NAME OF SCHOOL								DATE									20	
Last First Middle M F  ADDRESS  No. and Street City or Post Office Borough or Township County State Zip  REPORT OF EXAMINATION  TOOTH CHART  RIGHT  UPPER 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 Up  LOWER 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 Lo  UPPER	NAME OF CHILD									AGE		SEX			GRADE		SECTION/ROOM		
No. and Street   City or Post Office   Borough or Township   County   State   Zip	Last First 8								_										
TOOTH CHART   LEFT							'	Middle			<u></u>	IVI		!					
TOOTH CHART   LEFT   LEFT   LEFT   LOWER   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   No   Lowe	No. and Street City or Post Office								ugh or	or Township County State						State	9	Zip	
No     Date of Dental Examination   No     No	REPORT OF EXAMI	NATIC	N																
UPPER         1         2         3         4         5         6         7         8         9         10         11         12         13         14         15         16         UF           LOWER         32         31         30         29         28         27         26         25         24         23         22         21         20         19         18         17         Low           UPPER         Image: Composition of the c		TOOTH CHART																	
LOWER   32   31   30   29   28   27   26   25   24   23   22   21   20   19   18   17   Lower   Lowe		RIGHT								LEFT									
UPPER	UPPER	1	2	3			6 C		8 E	9 F	10 G				14	15	16	Upper	
Is The Child Under Treatment  Yes   No    Treatment Completed  Yes   No	LOWER	32	31	30	29 T										19	18	17	Lower	
Is The Child Under Treatment  Yes   No    Treatment Completed  Yes   No    Date of Dental Examination	UPPER																	Uppe	
Treatment Completed Yes No Date of Dental Examination	LOWER								:									Lowe	
	Treatment Completed										Yes 🗆					N	No 🗆		
	Date	of Den	tal Ex	amina	ation			_											
Signature of Dental Examiner  Print Name of Dental Examiner  Address	Signature of Dental Examiner							_	•	Print Name of Dental Examiner									