

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

**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				Upper
LOWER	32	31	30	T	S	R	Q	P	O	N	M	L	K	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