

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				Upper	
LOWER		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	Lower	
					T	S	R	Q	P	O	N	M	L	K					
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