

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____

NAME OF CHILD			AGE	SEX		GRADE	SECTION/ROOM
Last	First	Middle		<input type="checkbox"/>	<input type="checkbox"/>		

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 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper	
LOWER		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	
	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 _____