

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 <input type="checkbox"/> M <input type="checkbox"/> F	GRADE	SECTION/ROOM			
<table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;">LAST</td> <td style="width:33%; border: none;">FIRST</td> <td style="width:33%; border: none;">MIDDLE</td> </tr> </table>	LAST	FIRST	MIDDLE				
LAST	FIRST	MIDDLE					

ADDRESS \_\_\_\_\_

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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	22M	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