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
				☐ ☐
Last	First	Middle		M F

ADDRESS

No. and Street	City or Post Office	Borough or Township	County	State	Zip Code

REPORT OF EXAMINATION

								TOOTH CHART								
	RIGHT								LEFT								
Upper	1	2	3	4 A	5 B	6 C	7 D	8E	9F	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 ☐

Is The Child Under Treatment Yes ☐ No ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental/Examiner Print Name of Dental Examiner

_____
Address