

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 |
| _____             | _____ | _____ |     | <input type="checkbox"/> M | <input type="checkbox"/> F |       |              |
| Last First Middle |       |       |     |                            |                            |       |              |

ADDRESS

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

**REPORT OF EXAMINATION**

|       |       | TOOTH CHART |    |    |         |         |         |         |         |         |         |         |         |         |    |    |    |       |
|-------|-------|-------------|----|----|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|----|----|----|-------|
|       |       | RIGHT       |    |    |         |         |         |         |         | LEFT    |         |         |         |         |    |    |    |       |
| UPPER |       | 1           | 2  | 3  | 4<br>A  | 5<br>B  | 6<br>C  | 7<br>D  | 8<br>E  | 9<br>F  | 10<br>G | 11<br>H | 12<br>I | 13<br>J | 14 | 15 | 16 | Upper |
| LOWER |       | 32          | 31 | 30 | 29<br>T | 28<br>S | 27<br>R | 26<br>Q | 25<br>P | 24<br>O | 23<br>N | 22<br>M | 21<br>L | 20<br>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