

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