Fax 610 970 8738

H514 027

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
Last First Middle		M F		

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 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