

**PRIVATE DENTIST REPORT OF
DENTAL EXAMINATION OF A PUPIL OF
SCHOOL AGE**

NAME OF SCHOOL _____ DATE _____ 19____

NAME OF CHILD	AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	GRADE	SECTION/ROOM
Last First Middle				

ADDRESS _____

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	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

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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REPORT OF EXAMINATION

		TOOTH CHART																
		RIGHT								LEFT								
UPPER		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				
LOWER		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	Lower
	UPPER				T	S	R	Q	P	O	N	M	L	K				Upper
	LOWER																	Lower

Is The Child Under Treatment Yes No

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