

**COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HEALTH**

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

NAME OF SCHOOL \_\_\_\_\_ DATE \_\_\_\_\_ 20\_\_

|  |            |            |              |                     |
|--|------------|------------|--------------|---------------------|
| <u>NAME OF STUDENT</u>   | <u>AGE</u> | <u>SEX</u> | <u>GRADE</u> | <u>SECTION/ROOM</u> |
| _____<br>Last                      First                      Middle |            | M      F   |              |                     |

ADDRESS

\_\_\_\_\_  
 No. and Street              City or Post Office              Borough/Township              County              State              Zip

**REPORT OF EXAMINATION**

|              |              | <u>TOOTH CHART</u> |    |    |    |    |    |    |    |             |    |    |    |    |    |    |    |       |
|--------------|--------------|--------------------|----|----|----|----|----|----|----|-------------|----|----|----|----|----|----|----|-------|
|              |              | <b>RIGHT</b>       |    |    |    |    |    |    |    | <b>LEFT</b> |    |    |    |    |    |    |    |       |
|              |              | 1                  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9           | 10 | 11 | 12 | 13 | 14 | 15 | 16 |       |
| <u>UPPER</u> |              |                    |    |    | A  | B  | C  | D  | E  | F           | G  | H  | I  | J  |    |    |    | Upper |
| <u>LOWER</u> |              | 32                 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24          | 23 | 22 | 21 | 20 | 19 | 18 | 17 | Lower |
| <u>EXAM</u>  | <u>UPPER</u> |                    |    |    |    |    |    |    |    |             |    |    |    |    |    |    |    | Upper |
|              | <u>LOWER</u> |                    |    |    |    |    |    |    |    |             |    |    |    |    |    |    |    | Lower |

Untreated Decay: \_\_\_\_\_ No      Yes

Treated Decay: \_\_\_\_\_ No      Yes

Any Sealants on Permanent Molars: \_\_\_\_\_ No      Yes

Treatment Urgency: \_\_\_\_\_ None      Early      Urgent

\_\_\_\_\_  
 Date of Dental Examination

\_\_\_\_\_  
 Signature of Dental Examiner

\_\_\_\_\_  
 Print Name of Dental Examiner

\_\_\_\_\_  
 Address of Dental Examiner