

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION/SCREENING OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20__

NAME OF STUDENT	DATE OF BIRTH	GRADE	SECTION/ROOM
Last First Middle			
ADDRESS			

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

REPORT OF EXAMINATION/SCREENING

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

Untreated Decay: _____ No _____ Yes _____

Treated Decay: _____ No _____ Yes _____

Sealants on Permanent Molars _____ No _____ Yes _____

Treatment Urgency: _____ None _____ Early _____ Urgent _____

Date

Signature of Dental Provider Print Name of Dental Provider

Address of Dental Provider