

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 20____

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

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>								
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
<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