H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL Holy Family School DATE _____ 20_____

NAME OF CHILD			AGE	SEX	GRADE	SECTION
Last	First	Middle				
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 Child Under Treatment? **YES** ☐ **NO** ☐

Treatment Completed **YES** ☐ **NO** ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental/Examiner Print Name of Dental/Examiner

_____
Address