Revised 5/2016

Equivalent to form H514.027
Commonwealth of PA Dept. of Health

PRIVATE DENTIST REPORT OF DENTAL EXAMINATION

Date_____

Student Name _____ Date of Birth _____ Grade _____

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 the child under treatment? ❍ Yes ❍ No

Treatment Completed ❍ Yes ❍ No

_____

Date of Dental Examination

_____ _____

Signature of Dental Examiner Print Name of Dental Examiner

_____

Address of Dental Examiner