

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

NAME OF SCHOOL _____ DATE _____ 20 ____

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
_____ Last First Middle		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS

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

REPORT OF EXAMINATION

		TOOTH CHART																					
		RIGHT								LEFT													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16						
UPPER		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	Upper	
LOWER		T	S	R	Q	P	O	N	M	L	K	J	I	H	G	F	E	D	C	B	A	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