

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

NAME OF SCHOOL \_\_\_\_\_ DATE \_\_\_\_\_ 20 \_\_\_\_

NAME OF CHILD  _____ Last _____ First _____ Middle _____	AGE	SEX		GRADE	SECTION/ROOM
		<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								
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 \_\_\_\_\_