

**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 |
| _____<br>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  |    |    |    | Upper |
| LOWER | 32          | 31 | 30 | T | S | R | Q | P | O    | N  | M  | L  | 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