

**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
UPPER					A	B	C	D	E	F	G	H	I	J				Upper
LOWER		32	31	30	29	28	27	26	25	24	23	22	21	20	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