H514.027 (2/2024) COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF HEALTH

**PRIVATE DENTIST REPORT**

**OF DENTAL EXAMINATION/SCREENING OF A PUPIL OF SCHOOL AGE**

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

|  |  |  |  |
| --- | --- | --- | --- |
|  NAME OF STUDENT  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       Last                                First                                 Middle  | DATE OF BIRTH | GRADE  | SECTION/ROOM  |
|  ADDRESS  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No. and Street               City or Post Office              Borough/Township                County                  State             Zip   |
|  **REPORT OF EXAMINATION/SCREENING** |
|   | **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  |
| EXAM  |  UPPER  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |  Upper  |
|  LOWER  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |  Lower  |

Untreated Decay: No Yes

Treated Decay: No Yes

Sealants on Permanent Molars No Yes

Treatment Urgency: None Early Urgent

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

                Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

             Signature of Dental Provider                  Print Name of Dental Provider

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Dental Provider