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 \_\_\_

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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