



Have your Dentist fill out and return to your School Nurse at:
healthservices@hbgd.us or Fax: 717-703-4333 or 717-703-4040

COMMONWEALTH OF PENNSYLVANIA
 DEPARTMENT OF HEALTH

**PRIVATE DENTIST REPORT
 OF A STUDENT OF SCHOOL AGE**

NAME OF CHILD'S SCHOOL _____ BIRTHDATE _____

NAME OF CHILD:			AGE	SEX	GRADE	SECTION/ROOM
_____	_____	_____		<input type="checkbox"/> M <input type="checkbox"/> F		
Last	First	Middle				

 No. and Street City State Zip

REPORT OF EXAMINATION: Use 'd' and 'D' for Primary and Secondary Teeth with Decay

	TOOTH CHART																
	RIGHT								LEFT								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Circle Existing UPPER				A	B	C	D	E	F	G	H	I	J				Upper
Circle Existing LOWER	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	Lower
Decay: (d, D) UPPER																	Upper
Decay: (d, D) LOWER																	Lower

Treatment completed today: _____

➤ Is All Treatment Complete? Yes No

<p>If No:</p> <p>➤ Tooth Numbers needing Fillings: _____</p> <p>➤ Referral To Specialist: _____</p>
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 Date of Dental Examination

x _____
 Signature of Dental Examiner

x _____
 Print Name of Dental Examiner

 Address Stamp for Practice

 Office Phone Number