

Northern Tier Community Action Corporation
Head Start Program
P.O. Box 389
Emporium, PA 15834
Fax: (814)486-0519

DENTAL EXAMINATION REPORT

NAME OF CHILD			AGE	SEX	CENTER/HOME BASE		
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								
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
UPPER																	Upper
LOWER																	Lower

Does The Child Require Treatment? Yes No

Child Received Treatment? Yes No

Treatment Completed? Yes No

_____ Date of Dental Examination

_____ Signature of Dental Examiner

_____ Print Name of Dental Examiner

_____ Address