

REPORT OF PRIVATE DENTAL EXAMINATION

Name of School	Student ID		Date Issued	
Name of Student	Date of Birth	1	Room/Section/Book	Grade
TO THE DENTIST Pennsylvania law requires that stud tions at stated intervals (upon origin These examinations are required for	al entry, while in thing school attendance.	rd grade, and w Payment for th	rhile in seventh grade). ese examinations is the r	esponsibility of the
parent/guardian. If the student/famil health insurance. Please attach a c				
Thank you for your cooperation.				
UNDER TREATMENT / WORK BEGUN		COMPLETION OF WORK / NO TREATMENT NECESSARY		
Date Work Begun		☐ No Tr	eatment Required Now	
Scheduled Follow-up Appointment		All Necessary Dental Work Completed		
Date of Dental Examination		Expected Com	pletion Date	
Name of Dentist			Telephone	
ediatric Dental Excellence	(info@pediatricdentale	excellence.com	267 651 6900	
Signature of Dentist	,		Date Signed	
Address 3300 Henry Ave Falls Center Unit 1, Phila PA, 19129			Fax Number 267 651 6900	
IMPORTANT:				
Return this form to:	Certified School Nurse/Practitioner			* * *
	School			DENUSTRY EVENTORY
	School Address			*- SVERY CIM
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