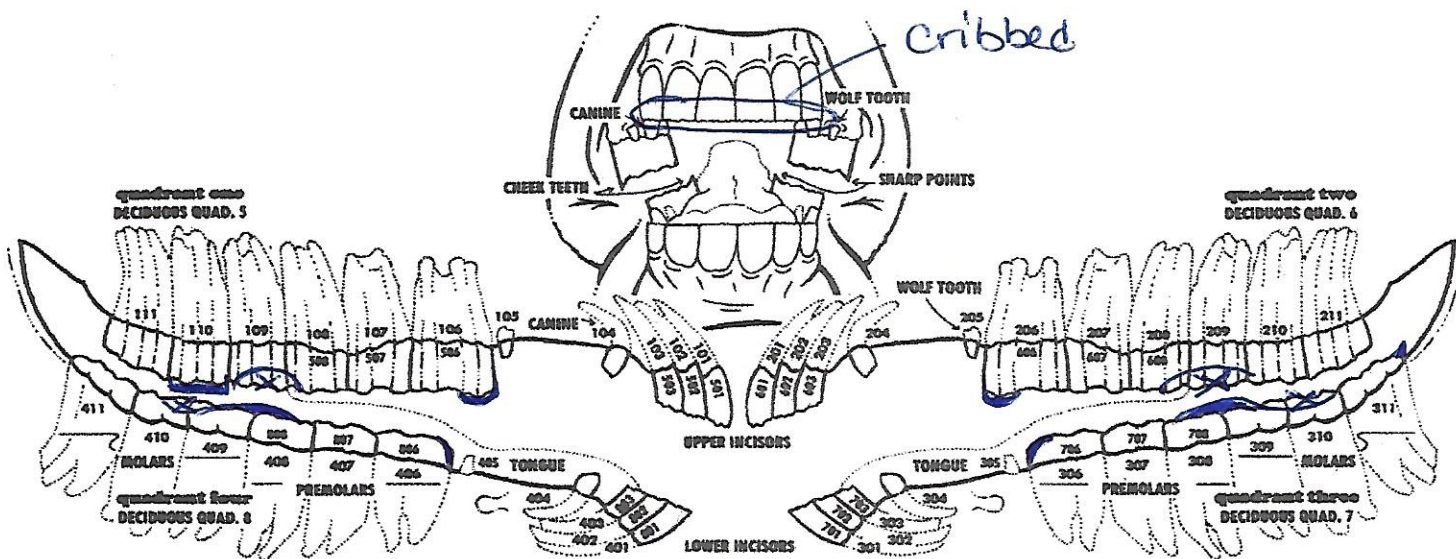


EQUINE DENTAL RECORD

Date 5-1-16

Owner: John Doe Phone: (123) 456-6789 Cell Phone _____
 Address: 123 Random Dr. City: Mason State: MI Zip: 48854
 Equine Name: Ivy Age: 11yr Sex: Male / MC / Female
 Breed: Paint Color: Blk/wht. Condition: 1 2 3 4 5 6 7 8 9
 Use: Pleasure Performance Racing Other Bit: Snaffle/ Feed: Graze / Hay / Processed



HISTORY/COMMENTS: Maintenance - reduced Stepped 110/210 ulcers and sharp pts reduced on buccal & lingual areas - abrasions present
reduced bulbed rostral 106/206
reduced 308/309 408/409 waves - damage to 109/209 cupped
reduced 311 caudal ramp Horse is a cribber - cleaned up chips on incisors
 VITALS: WNL HR: WNL /RSP: WNL /OVERALL WELLNESS: _____
 VETERINARIAN: FILLED IN BY Attending Vet with contact info
 SEDATION USED: FILLED IN BY Attending Vet

INCISORS		CANINES	WOLF TEETH	PREMOLARS/MOLARS	
<input type="checkbox"/> Ventral Curve	<input type="checkbox"/> Realign	<input type="checkbox"/> Cut	<input type="checkbox"/> Extract	<input checked="" type="checkbox"/> Float	<input checked="" type="checkbox"/> Stepped
<input type="checkbox"/> Dorsal Curve	<input type="checkbox"/> Reduction	<input type="checkbox"/> Buff	<input type="checkbox"/> Upper	<input checked="" type="checkbox"/> Bitseat	<input checked="" type="checkbox"/> Sharp Points
<input type="checkbox"/> DGL 3	<input type="checkbox"/> Angle Change	<input type="checkbox"/> Remove Tarter	<input type="checkbox"/> Lower	<input checked="" type="checkbox"/> Reduced	<input type="checkbox"/> Caps
<input type="checkbox"/> DGL 4	<input type="checkbox"/> Extract	<input type="checkbox"/> Elevate	<input type="checkbox"/> Anterior	<input type="checkbox"/> Balance	<input type="checkbox"/> Cap Fragments
<input type="checkbox"/> Caps	<input type="checkbox"/> Missing	<input type="checkbox"/> Blind	<input type="checkbox"/> Lingual	<input type="checkbox"/> Extract	<input type="checkbox"/> Impacted
<input type="checkbox"/> Cap Fragments	<input checked="" type="checkbox"/> Other	<input type="checkbox"/> Fracture	<input type="checkbox"/> Buccal	<input type="checkbox"/> ETR	<input type="checkbox"/> Supernumerary
<input type="checkbox"/> Supernumerary	<u>Chips on upper incisors</u>	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Fragment	<input checked="" type="checkbox"/> Hooks	<input type="checkbox"/> Expired
<input type="checkbox"/> Overjet/Overbite		<input checked="" type="checkbox"/> None	<input type="checkbox"/> Blind	<input checked="" type="checkbox"/> Ramps	<input type="checkbox"/> Fractured
<input type="checkbox"/> Underjet/Underbite		<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Other <u>none</u>	<input checked="" type="checkbox"/> Wave	<input type="checkbox"/> Mobile
<input type="checkbox"/> Abnormal				<input type="checkbox"/> Protuberant	