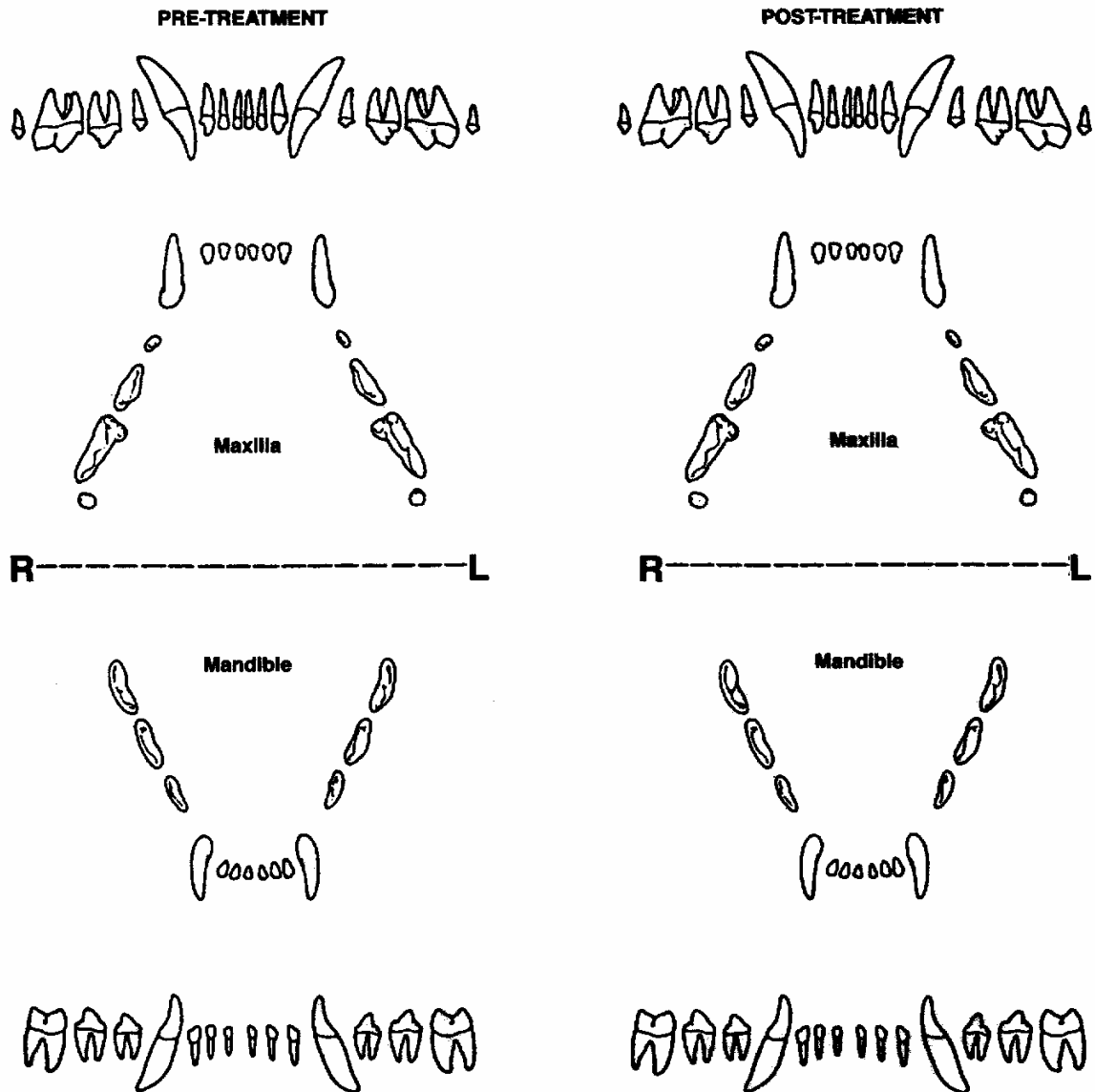


		Patient No:	
Patient:		Owner:	
Breed:	Age/Sex:	Phone No:	Date:
Chief Complaint:		Occlusion:	
Past Dental History:			



Recommended Homecare:	<input type="checkbox"/> Brushing	<input type="checkbox"/> Oral Gel	<input type="checkbox"/> Diet
Antibiotics:	Anti-inflammatory:		
Recommended Re-visit Schedule:			
Comments:			

Chart courtesy of Pharmacia & Upjohn.