

Dental Authorization Form – Date

To insure the best care possible, **please**, take the time to fill out this form completely.

CLIENT INFORMATION

Owner's Name: _____
Address : _____
Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____

Patient's Name: _____
Breed: _____
Weight: _____
Sex: _____
Age: _____
Color: _____
Microhip No: _____

DENTAL PROCEDURE:

I, hereby, consent and authorize Indian Head Animal Hospital, its doctors and technicians to perform a dental cleaning and polishing on my pet. I understand that just as there may be risks and hazards in continuing your pet's present condition without treatment, there are also risks and hazards related to the performance of any surgical, medical, anesthetic and/or diagnostic procedures planned for your pet. In addition, a complete dental examination will be completed as part of the dental procedure. The health of the teeth and degree of periodontal disease is often best assessed when the pet is under anesthesia. At that time, diseased or fractured teeth are often found that may require medical attention and often extraction.

Yes **No** - Did your pet receive any food after 12 PM?

PRE-SURGICAL BLOOD TESTS:

Preoperative screening greatly reduces anesthetic risks by detecting system irregularities like anemia, kidney and liver dysfunction. We strongly **recommend that pre-op screening** be performed in the best interest of your pet's health.

Yes; I want my pet to have pre-surgical blood profile (\$_____)

INIT _____ **No**; I do not want my pet to have pre-surgical blood profile. I fully understand the possible consequences of anesthesia and dentistry being performed without this vital information.

CONSENT FOR TOOTH EXTRACTIONS:

In many gum disease cases, extraction of diseased teeth is necessary to prevent further infection and pain. I give permission for the veterinarian to extract any necessary teeth?

Yes. Extractions will result in additional charges.

INIT _____ **No**; please contact me at this number () _____ prior to any extractions. We will make every effort to contact. If we can't reach you by phone during the procedure, we require your prior consent to extract any severely diseased teeth. Extractions will result in additional charges.

PAIN RELIEF:

If the attending veterinarian deems it appropriate, pain relief may be provided to your pet after surgery.

Yes; I want my pet to have post-op pain relief if necessary (\$_____)

INIT _____ **No**; I do not authorize the administration of post-op pain relief.

ADDITIONAL REQUESTED SERVICES:

(i.e. mass removals, vaccines, nails, anal glands):

ANTIBIOTIC:

Liquid Pill - If necessary, which type of antibiotics do you prefer to give your pet?

MICROCHIP:

Permanent system for easy identification of your pet.

Yes, please microchip my pet (\$50.00)

No, thank you

PAYMENT AND ESTIMATE REQUEST

Yes, I would like an estimate for the procedure.

No, I do not need an estimate.

INIT _____ **I understand payment for all treatment is due and payable when I pick up my pet.**

DISCHARGE APPOINTMENT

Please schedule your pet discharge appointment time with the reception at this time.

In case of emergency notify: _____

Phone _____

Owner's Signature: _____

Date of admission: _____

(Must be over 18 years to sign)

Please note this facility is not staffed 24 hours a day