All Creatures Animal Hospital Dental Agreement

Owner: _____ **Patient name:** _____ **Account #**_____

<u>Anesthetic and surgical procedures to be performed:</u>

Ultrasonic Dental, Polish with Fluoride Treatment

I, the undersigned owner or agent of the pet identified above, authorize the veterinarians at All Creatures Animal Hospital to pe procedures. I understand that some risks always exist with anesthesia and/or surgery, and I am encouraged to discuss any about those risks with the attending veterinarians before the procedures are initiated.

1. In effort to provide the best care available for your pet, we recommend pre-anesthetic bloodwork to help insure your loved one will not have adverse effects from the anesthesia. All animals will benefit from bloodwork, but we strongly urge all large breed dogs over 5 years of age and require all pets over 7 years of age, to have blood work performed within the last 6 months.

_____ Yes, I would like to insure my pet does not have any pre-existing health problems that might adversely affect the anesthesia.

_____ No, I do not wish to have any bloodwork performed on my pet.

2. In all patients, IV catheterization and fluids is highly recommended to further reduce the risks associated with anesthesia. The benefits include immediate venous access for the administration of medications, support of blood pressure and prevention of dehydration.

_____ Yes, I would like to further reduce the risk of anesthesia by approving the placement of an IV catheter and administration of fluids.

_____ No, I do not wish to have an IV catheter placed and fluids administered during the procedure.

3. In some cases dental extractions may be necessary, and therefore pain relievers and/or antibiotics required.

_____ Yes, I approve any medically necessary dental extractions with pain relievers and/or antibiotics.

_____ No, I do not approve any medically necessary dental extractions without my verbal approval.

4. In some cases where tissue is removed, examination of the tissue by a pathologist may be indicated.

_____ Yes, please submit the tissue for review by a pathologist.

_____ No, I do not desire histopathology.

While I accept that all procedures will be performed to the best of the abilities of the staff at this hospital, I understand that no g warranty has been made regarding the results that may be achieved.

I understand that any prices quoted for such procedures are for non-complicated operations and that any unforeseen complica in further cost. I assume financial responsibility for all charges incurred for this patient, and I consent to the release of medica the said animal.

I have read and fully understand the terms and conditions set forth above.

_____ _____ _____

Signature of Owner or Authorized Agent **Date** **Email (For hospital use only)**

_____

Phone numbers at which owner or agent can be reached today and/or tomorrow

Name of staff who checked in: _____