



North Seattle Veterinary Clinic | 11032 8th Avenue NE | Seattle, WA 98125 | 206-523-7187 | info@northseattlevet.com

### Dental Procedure Authorization Form

Client Name: \_\_\_\_\_ Patient: \_\_\_\_\_

Procedure: \_\_\_\_\_

#### **Extraction Consent:**

Once your pet is anesthetized the veterinarian will thoroughly examine your pet's teeth and review dental x-rays. Your veterinarian will then call you with these results and discuss any recommendations. If any additional dental work (such as a tooth extraction) is recommended, then an updated estimate on cost will be provided. If your veterinarian is unable to contact you or your authorized agent, we need to know your preferences:

#### **If contact cannot be made at the phone numbers provided within 15 minutes, I prefer the following:**

- Proceed with all recommended procedures, including tooth extractions, as determined by the doctor.
- Proceed with recommended procedures, including unforeseen tooth extractions up to \$ \_\_\_\_\_.
- Do not extract any teeth or perform any additional treatments. I understand that no work will be performed, and an additional anesthetic procedure may be needed. This will increase the cost of treatment.
- I prefer my pet be referred to a board-certified veterinary dental specialist, and do not authorize any treatments or extractions.

#### **Post-Operative Pain Control:**

- I prefer giving oral tablet medications.
- I prefer giving oral liquid medications.
- I am unable to give any oral medications and prefer injection medication when possible.

#### **Additional services request:**

I would like NSVC to perform these additional treatments while my pet is in the facility:

- Nail trim with anesthesia (\$4)
- Ear cleaning/flush (cost \$38 - \$54)
- Microchip placement (cost \$54, includes registration)
- Administer vaccinations due (cost varies - \$27- \$64 each)
- Oravet Application (cost \$24 - \$68) - This dental sealant helps prevent bacteria and tartar build up.
- Oravet kit to take home and apply once weekly (cost \$47.34 + tax, about 3-4-month supply)

*I understand that no guarantee or warranty for success or outcome can be given and that some risks are involved in all anesthetic procedures. The risks have been explained to my satisfaction and North Seattle Veterinary Clinic has my permission to perform the procedures as listed above. I understand North Seattle Veterinary Clinic is not open for overnight care and is not staffed by a medical team after hours. I understand that I assume financial responsibility for all services rendered, and that payment is due at the time I pick up my pet.*

Client Signature \_\_\_\_\_ Date: \_\_\_\_\_

Contact Phone Number #1 \_\_\_\_\_ Text message okay: Y / N

Contact Phone Number #2 \_\_\_\_\_ Text message okay: Y / N

{OFFICE USE ONLY} Technician/DVM Witness (initials) \_\_\_\_\_ Discharge Time \_\_\_\_\_

## Patient Medical History

Client Name: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Diet: \_\_\_\_\_ Last Meal: \_\_\_\_\_ AM / PM

**Please list all medications or supplements your pet is taking:**

Medication / Supplement	Dose	Time Last Dose Given

**For patients receiving an anesthetic:** Has your pet received their Comfort Pack (Cerenia & Gabapentin)?

Yes / No If yes, when was it given? \_\_\_\_\_

**Any prior reactions/allergies to medications or vaccinations?** Yes / No

If yes, please describe: \_\_\_\_\_

**Has your pet shown recent signs of illness such as vomiting, diarrhea, coughing or sneezing?** Yes / No

If yes, please describe: \_\_\_\_\_

**Has your pet shown changes in appetite, drinking or exercise habits?** Yes / No

If yes, please describe: \_\_\_\_\_

**Please list any other concerns about your pet:** \_\_\_\_\_

\_\_\_\_\_

**Please list any belongings left with your pet** (*The clinic will not be responsible for lost items.*): \_\_\_\_\_

\_\_\_\_\_

**For dogs and cats, please list the type and latest dose of flea medication provided to your pet:**

Type: \_\_\_\_\_ Date Given: \_\_\_\_\_

**Please list any behavioral or handling concerns** (*fear biting, dog aggression, pain, etc.*): \_\_\_\_\_

\_\_\_\_\_

*The information provided on this form is true to the best of my knowledge. I also accept that if evidence of live fleas is found on my pet that a dose of flea medication will be given to my pet at a cost not to exceed \$26. (This policy protects your pet as well as others in the clinic.)*

**Client signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*{OFFICE USE ONLY}* Technician/DVM Witness (initials) \_\_\_\_\_