Veterinary Associates, LLC

**●●● 19922 US Hwy 10, Reedsville, WI ●●● (920) 754 - 4307 ●●●**

**Dental (Teeth cleaning and/or extractions) Consent Form**

**Owner/Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your pet must be dropped off between 7:30 am and 8 am the day of teeth cleaning (Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_). No one is at the clinic before 7:30 am.

No food (or treats!) after 10pm the night before surgery. Water is ok until time of drop off. **FASTED** **YES**\_\_\_\_\_ **NO**\_\_\_\_\_

Please notify us of any pre-existing health concerns that you’re aware of (e.g. diabetes, seizures, heart disease, etc) as well as any medications/supplements your pet may be currently taking. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, owner or authorized agent of patient/**pet** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the admitting veterinarian (and designated associates, technicians or assistants) to administer treatment as necessary to perform the following dental prophylaxis (teeth cleaning), complete oral evaluation and (**please initial ONE option below**):

|  |  |
| --- | --- |
|  | Perform any necessary extractions necessary. Your pet will be started on pain medication and/or antibiotics. |
|  | Call me after the dental exam if procedure/extractions will be higher than estimate, previously provided. I understand that if *I CANNOT be contacted* at the number listed below, *necessary extractions will be* performed and my pet may be started on pain medication and/or antibiotics at my cost. |

I also consent to the administration of sedatives and/or anesthetic, as necessary, to complete the above procedures.

If we find that removing (extracting teeth) is indicated, our approach is to remove only those teeth that must be extracted. We will only remove loose and fractured teeth. Dental procedures, including simple and surgical extractions can be associated with risks. I understand these risks may include broken tooth roots, bleeding, dry sockets, and damage to surrounding tissues. Rarely, fractures of the bone may occur, necessitating referral to a dental specialist.

Dental x-rays are valuable in evaluating overall tooth health. At this current time, Veterinary Associates LLC does not have dental radiography. If any “questionable/marginal” teeth are identified, I am aware that the attending veterinarian will leave such teeth, and treatment or extraction may be required in the future, at my financial responsibility.

If possible, all dental work (cleaning, polishing, extractions, and fluoride treatment) will be completed within one visit. However, on occasion, when difficult, lengthy procedures are needed, a veterinary dental specialist will be consulted. Our goal is to give your pet the best dental care possible in a safe and efficient manner.

**PRESURGICAL BLOODWORK -** Sometimes pre-existing conditions are present that may not be physically evident. For this reason, we feel all pets need (required if 7 years old or older; or by Doctor discretion) pre-anesthetic blood profiles. The profile includes a complete blood count (evaluate red and white blood cells, platelets) and glucose (blood sugar), parameters to check liver and kidney function, and electrolytes. **$60.00**  **YES**\_\_\_\_\_ **NO**\_\_\_\_\_

**INTRAVENOUS CATHETER** – An I.V. catheter, required for all dental procedures, is placed prior to the procedure and can help keep your pet’s blood pressure normal and helps to flush the anesthetic out of their system faster. **$40.00**

**CPR -** I understand that there may be risk involved in these procedures. In the event of a cardiopulmonary arrest (loss of normal heart beat and breathing), I understand immediate action must be taken. I authorize the following (please select one option):

 **Yes**, Cardiopulmonary Resuscitation (CPR) as deemed necessary by the doctor to try to restore normal heart beat & breathing. (Additional charges may apply)

 **No** resuscitation efforts

I further understand that no guarantee of successful treatment is made. I hereby certify that I have read and understand this authorization, the reasons that this procedure is considered necessary, as well as its advantages and possible complications. I will not hold Veterinary Associates, doctors, or staff liable for any complications. I assume financial responsibility for all charges incurred to the patient and agree to pay all charges at the time the patient is discharged.

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Number you can be reached all day Signature of owner or responsible agent (**must be 18yrs of age)** Date

Please call me when my pet is out of surgery (usually after 1pm) **YES**\_\_\_\_\_ **NO**\_\_\_\_\_ Pick-up Time \_\_\_\_\_\_\_\_\_\_\_\_

(between 3-5pm)

Payment is required in full at the time of all small animal services. We accept cash, credit card, care credit or check.