Critter Care Animal Clinic

Date:

Patient ID:	Pet:
Client:	Species:
Address:	Breed:
City, State:	Sex / Color:
Zip Code:	Microchip:
Phone:	Birthdate:

The following information is necessary in order that we might serve you better and give you more personal attention.
Please fill out the form completely and double check your personal information to be sure everything is current.

AUTHORIZATION FOR SURGICAL DENTAL CLEANING

I, owner or authorized agent of admitted patient, hereby authorize the admitting veterinarian (and his/her designated associates or assistants) to administer treatment as necessary to perform the following surgical, dental or diagnostic procedure, and additional procedures as are considered therapeutically and/or diagnostically necessary. I also consent to the administration of such anesthetic as necessary. I hereby authorize performance of the following procedure(s):
DENTAL CLEANING/EXAMINATION UNDER ANESTHESIA _____ .

In addition to the above procedure, while your pet is under anesthesia he/she may receive a complimentary ear cleaning and nail trim. If you would prefer that we NOT do these services, please let us know.

Home Again Microchip - (Includes one year registration) $45 ☐ Yes ☐ No ☐ Pet is microchipped

Pre-anesthetic Bloodwork - Sometimes pre-existing conditions are present that may not be physically evident. For this reason, we offer pre-anesthetic blood profiles that include measurements of liver and kidney function, red blood cell count,
☐ Yes ☐ No

Tooth extractions - We cannot know if teeth will need to be removed until we have performed an exam under anesthesia. We only remove teeth that we feel are causing pain or could be a source of problems including infection. Often pets do not show outward signs of dental pain. If we feel teeth need to be removed, how should we proceed? Extractions vary on cost depending on type of tooth and extent of disease - $20-100 per tooth. Please **initial** ONE of the following:
____ Remove any teeth that need to be extracted with the understanding there will be additional charges.
____ Please call me at the number listed below first, but if you cannot reach me, you may proceed with any extractions.
____ Do nothing else unless you reach me first. I understand you will wake my pet without doing even the simplest procedure.

Dental radiographs - Dental radiographs help us determine overall health of the teeth and jaw. They also help us determine if a tooth needs to be removed and if it can be removed safely. Radiographs are also very important when extracting teeth to confirm entire root was removed. Please **initial** ONE of the following:
____ Perform full mouth radiographs of all teeth - $85 (strongly recommended)
____ Perform radiographs only of teeth being extracted - $25/view not to exceed $85
____ Do not perform radiographs. I understand this is against medical recommendations.

Therapeutic Laser - This can be performed after surgery to help reduce pain and inflammation as well as speed healing of tissue of extraction sites. Only recommended if extractions performed. $15 ☐ Yes ☐ No

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, if any. I will not hold Critter Care Animal Clinic, the doctors, or the 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.** I understand that if my pet is not current on his/her rabies vaccination, it will be updated at the time of service. I also understand that any patients found to have fleas will be treated at the owner's expense.

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 ONE following: (please **initial**)
____ Cardiopulmonary Resuscitation (CPR) as deemed necessary by the doctor to try to restore normal heart beat & breathing. (Additional charges will apply)
____ No resuscitation efforts

Date:_____ Signature:_____ Emergency Phone Number:_____
Fasted: ☐ Yes ☐ No