6349 Technology Dr., Frisco, TX 75034

469-358-0698

FAMILY PET CENTER

Dental Agreement

Owner Name: ____

Patient Name: ____

Anesthetic & Surgical Procedures to be Performed: Ultrasonic Dental, Polish with Fluoride Treatment

I, the undersigned owner or agent of pet identified above, authorize the Veterinarians of Family Pet Center to perform the above procedures. I understand that some risks always exist with anesthesia and/or surgery, and I am encouraged to discuss any concerns I have about those risks with the attending Veterinarians before the procedures are initiated.

1. In an 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 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 bloodwork 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 by authorizing Family Pet Center to perform pre-anesthetic bloodwork on this patient.

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

2. In all patients, IV catheterization and fluids are 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 during anesthesia and prevention of dehydration.

__________ Yes, I would like to further reduce the risk of anesthesia by authorizing Family Pet Center to proceed with the placement of an IV catheter and administration of fluids to this patient.

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

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3. In some cases dental extractions may be necessary and therefore pain relievers and/or antibiotics may be 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 understand that all procedures will be performed to the best of the abilities of the staff of Family Pet Center, I understand that no guarantee or 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 complications may result in further cost. I assume financial responsibility for all charges incurred to the patient and I consent to the release of medical information for 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: ______________________

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