

FERRY FARM ANIMAL CLINIC Ltd.
DENTAL CONSENT FORM

OWNER'S NAME _____

PATIENT'S NAME _____

PRINTED NAME OF CONTACT PERSON _____

PHONE NUMBER OF CONTACT PERSON _____

I am the owner or agent for the owner, of the above animal and have the authority to execute this consent form. I hereby consent and authorize the performance of anesthesia/prophy (teeth cleaning)/polishing/fluoride.

AND

_____ Extractions and x-rays as indicated

_____ I WOULD LIKE TO BE CALLED PRIOR TO ANY EXTRACTIONS OR X-RAYS

_____ IF I CAN NOT BE REACHED AT THE CONTACT NUMBER THAT I HAVE PROVIDED, I AUTHORIZE THE ATTENDING VETERINARIAN TO PREFORM DENTAL PROCEDURES AS DEEMED NECESSARY.

I understand that unforeseen conditions may develop, or be revealed that necessitates an extension or alternation of the procedure(s) or service(s) described above. In the event that I am unable to be contacted at the number above or if a situation develops that required immediate attention, I authorize the attending veterinarian to use his/her professional judgement as deemed necessary in the performance of the above procedure(s) and service(s) or other medical conditions that might arise.

I have been advised as to the nature of the procedure(s) or service(s) and the risks involved. I understand that there may be additional risks involved. I realize and understand that the results or outcome of any medical/surgical procedure cannot be guaranteed.

In the event fleas or ticks are noted on my pet, I understand that Ferry Farm Animal Clinic will apply appropriate parasite control medication while my pet is hospitalized, and that I will be charged for the medication.

INITIAL _____

We strongly recommend pre-anesthetic blood testing on all patients 7 years of age and older prior to sedation or anesthesia, unless it has been preformed in the previous 60 days. While this does not guarantee that there will not be complications from anesthesia, it gives a better opportunity to evaluate your pet's anesthetic risk. This will help evaluate the liver, kidneys and red blood cells. The cost for this testing is \$40.00. Please initial your preference below:

ACCEPT _____

DECLINE _____

I HAVE READ AND UNDERSTAND THIS TREATMENT CONSENT FORM.

I UNDERSTAND THAT THE COST OF EXTRACTIONS CAN RUN ANYWHERE FROM \$8.00 TO \$65.00 PER TOOTH.

DATE

SIGNATURE