SOUTHGATE ANIMAL CLINIC

7851 SE King Rd. Milwaukie, OR 97222 Phone: 503-771-0857 Fax 503-771-2170

# DENTAL TREATMENT CONSENT

**Client Name: _____ (Please print) Phone Number: _____**

**Patient Name: _____ Age: _____ Breed: _____ Canine/ Feline Male/ Female**

**Medical History**

**Has your pet had any treats or food in the past 8 hours? ☐ Yes ☐ No If so what time? _____**
**Is your pet experiencing any vomiting, coughing? ☐ Yes ☐ No**
**Is your pet taking any medications? ☐ Yes ☐ No**
**If yes, please list _____**
**Do you use dental hygiene products on your pet? ☐ Yes ☐ No**
**If yes, please list _____ :_____**

**Elective procedures to be performed:**
**Please circle: ☐ Express anal glands $19.50 ☐ Clean ears $30.00 ☐ Nail trim $0 Other _____**

**Intravenous Catheter and fluids:**
**An IV catheter will be placed prior to undergoing anesthesia. IV fluids improve blood pressure, assist in processing the anesthetic agents, compensate for blood loss and provide a direct line in case of emergency.**

**Pre-anesthetic testing:**
**Your pet is scheduled for anesthesia and dental treatment Any anesthetic procedure has potential risk. Therefore, we recommend a blood profile for all pets and require it for pets over 7 years of age, to ensure that your pet is in suitable condition prior to this procedure. We are able to perform quick and accurate blood tests before your pet's. anesthetic induction. These tests are the same that your doctor would request before you would undergo anesthesia.**

**Please initial _____YES: I hereby consent to the recommended pre-anesthetic tests.**

**Please initial _____NO: I decline the recommended pre-anesthetic tests. I understand the potential risks by the omission of these tests. I assume full responsibility for my pet should complications arise.**

- **Recommended pre-anesthetic tests have already been completed on :_____**

**Consent to perform extractions and necessary procedures:**
**A full dental exam is performed once your pet is under anesthesia. Until then we cannot detect every dental problem your pet may have. A staff member will call you to update your estimate if additional services are needed. We**

**recommend completing all needed dental procedures during this visit to help reduce stress on your pet and additional anesthesia costs.**

**Please check one of the options below:**

□ **Perform any needed procedures &/or extractions.**

□ **Call me after the dental exam end provide an updated estimate of any additional procedures**

**You can reach me at _____ or _____.**

- □ **If unable to reach me, do what is needed.**
- □ **If unable to reach me, provide only the requested dental plan as per my written estimate. I understand my pet will need to undergo another anesthetic procedure in the future.**

Southgate Animal Clinic will make every attempt to contact the owner if **EMERGENGY** treatments are required while an animal is in our care. **I ☐ do ☐ do not**
**authorize emergency treatment if Southgate is unable to reach me.**

**I agree to the above terms and conditions. I have reviewed the estimate provided to me and I agree to pay the full amount when my pet is discharged from Southgate Animal Clinic.**

****All animals found to have an existing flea population will be treated with an appropriate flea product.**

**Signed: _____ Date: _____**