



## Desert View Animal Hospital

940 Elk Street  
 Rock Springs, WY 82901  
 (307) 362-3184

### Anesthesia and Dental Procedure Consent

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

Client: \_\_\_\_\_

#### Complete Oral Assessment, Treatment and Prevention

A basic dental cleaning includes the following:

- General anesthesia, monitoring and technician care and recovery
- Oral examination by Veterinarian
- Ultrasonic scaling above and below the gum line, polishing the teeth
- Probing for gingival pockets and abscesses
- Fluoride treatment of all teeth depending on patient needs
- Complete dental charting

Costs for a **basic** dental vary according to length of procedure and size/weight of the patient. Extractions, tooth fracture repair and other corrective procedures will have additional costs. **A \$250.00 deposit is required on the day of the patient's scheduled dental.**

	Additional Procedures	Accept	Decline
Pre-anesthetic Lab Work <b>\$ 120.00</b> (Includes Blood Draw Fee)	Lab tests recommended better evaluate your pet internally and establish a baseline for future reference <input type="checkbox"/> Complete Blood Cell Count/Pre-anesthetic Screen* <b>*REQUIRED FOR DOGS OVER 9 YEARS, GIANT DOG BREEDS OVER 5 YEARS AND CATS OVER 12 YEARS</b> <input type="checkbox"/> Other _____	[ ]	[ ]
Intravenous Catheter and Fluids <b>\$ 39.00</b>	<b>REQUIRED FOR DOGS OVER 9 YEARS, GIANT DOG BREEDS OVER 5 YEARS AND CATS OVER 12 YEARS</b> <b>REQUIRED FOR EXTENDED AND ADVANCED PROCEDURES</b>	[ ]	[ ]
Pre-anesthetic ECG Screen <b>\$ 55.00</b>	Assess cardiac rhythm for irregularities that may complicate anesthesia  May be required at the Doctor's discretion	[ ]	[ ]

**Possible Additional Costs:** After an oral examination, we may recommend dental radiographs, tooth fracture repair, periodontal treatments and/or extractions. Costs for simple extractions are \$5-\$30 per tooth but can range as high as \$50 for more involved extractions. Many pets require no additional work but further costs can range as high as \$1,100 with severe oral disease.

**PLEASE CHOOSE ONLY ONE OPTION**

[ ]	Call me after the dental exam and provide an estimate of any additional procedures. I understand that if I cannot be contacted at this number, necessary radiographs, extractions or other dental procedures will be performed and my pet will be started on antibiotics and pain medication. I agree to assume financial responsibility for these additional charges.
[ ]	Call me after the dental exam and provide an estimate of any additional procedures. Do not proceed without authorization. I understand that if I cannot be contacted at this number no radiographs, extractions or other dental procedures will be performed and I will assume all responsibility for any complications this decision may cause for my pet. I also understand that if I decide to have these additional services done later, I have to schedule for a different appointment with separate charges.

\_\_\_\_\_ I am the owner, or the owner's agent, of the above-described animal and I have the authority to execute this consent. I hereby consent and authorize the above procedures.

\_\_\_\_\_ I hereby authorize Desert View Animal Hospital to perform the above procedures and additional diagnostic, treatments, or surgical procedures as deemed necessary for medical or surgical complications or otherwise unforeseen circumstances. I also authorize the use of appropriate anesthetics and other medications.

\_\_\_\_\_ The nature of the procedures(s) has been explained to me and no guarantee has been made as to the results of the procedure. I understand that there may be risks involved in these procedures and with any anesthesia or pain medication. **I will not hold Desert View Animal Hospital, the Doctors, or the staff liable for any complications.**

\_\_\_\_\_ Should my animal unexpectedly require CPR or other life-saving emergency care and the hospital staff is unable to reach me, the staff: (initial one)

\_\_\_\_\_ HAS

\_\_\_\_\_ DOES NOT HAVE

my permission to provide such treatment and I agree to pay for such services at the time my bill is due.

\_\_\_\_\_ I understand that hospital support staff will be used as deemed necessary by the veterinarian. I also understand that Desert View Animal Hospital is not staffed twenty-four (24) hours a day and after hour treatment of patients is at the discretion of the veterinarian.

\_\_\_\_\_ Payment is expected when services are rendered, unless prior arrangements are made and approved in advance. **Should I fail to pay at any time any portion of the bill for my pet's care, I agree to pay the costs of all delinquency charges, collection charges and reasonable attorneys' fees. Delinquency charges are 50% of the unpaid balance.** I have read and understand this authorization of consent.

**I agree to pay the balance of the above estimated fees at the time of my pet's discharge.**

\*\*\*Care Credit – Must be approved or have a valid account at the time of admittance

Date: \_\_\_\_\_

Owner/Agent: \_\_\_\_\_

Contact Phone: \_\_\_\_\_

Witness to Signature: \_\_\_\_\_

Please list any medications or supplements your animal may have had within the last 7 days and when the last dose was given: \_\_\_\_\_

\_\_\_\_\_