

# Apple Valley Animal Hospital

1207 Cedar Creek Grade – Winchester, Va 22602 (540) 678-0202



## DENTAL CONSENT FORM

Owner: \_\_\_\_\_ Pet: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize and direct the veterinarians of the Apple Valley Animal Hospital to perform a dental prophylaxis on my pet. I understand that any additional procedures and/or treatments may increase the final cost. I understand that the hospital requires all pets be current on their vaccinations, be free of all parasites, and have had a recent physical examination. I realize there is always a risk when anesthetics and other medications are used and when a dental is performed. I also know that results cannot be guaranteed. The doctors have my permission to do what they view necessary for my pet today.

**I understand that some unhealthy teeth may fall out on their own during this dental procedure. Initial** \_\_\_\_\_

The Apple Valley Animal Hospital has medical staffing: Monday through Friday 7am - 6pm and Saturdays 8am - 1pm. If the doctor feels it is necessary, you will be asked to take your pet to the Veterinary Emergency Center for overnight care.

**My pet has had nothing to eat in the last 8 hours. Owner's Initials:** \_\_\_\_\_

**Where can we reach you today?** \_\_\_\_\_

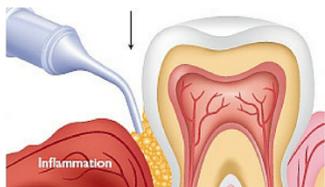
**Estimate** of today's services: \_\_\_\_\_ or [ ] See estimate in file.

**Payment is due when pet is picked up from surgery. Initial** \_\_\_\_\_

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**If the doctor finds something unexpected, I would like the following steps taken:**

- \_\_\_ Do not perform any extra services to my pet.
- \_\_\_ You do not need to call me, do what is best for my pet within \$ \_\_\_\_\_
- \_\_\_ Call me before performing any other services. # \_\_\_\_\_



**If my pet has unhealthy gums** and an antibiotic treatment medically placed under the gums could help heal the gum and help prevent my pet from losing that tooth, please do the treatment. [ ] YES [ ] NO **Initial** \_\_\_\_\_  
**(The cost for this is \$72.00 no matter how many teeth need to be treated.)**

Signature of Owner \_\_\_\_\_ Date \_\_\_\_\_

# Winchester Animal Hospital

901 North Loudoun Street – Winchester, Va 22601 (540) 667-0260



## DENTAL CONSENT FORM

Owner: \_\_\_\_\_ Pet: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize and direct the veterinarians of the Winchester Animal Hospital to perform a dental prophylaxis on my pet. I understand that any additional procedures and/or treatments may increase the final cost. I understand that the hospital requires all pets be current on their vaccinations, be free of all parasites, and have had a recent physical examination. I realize there is always a risk when anesthetics and other medications are used and when a dental is performed. I also know that results cannot be guaranteed. The doctors have my permission to do what they view necessary for my pet today.

**I understand that some unhealthy teeth may fall out on their own during this dental procedure. Initial** \_\_\_\_\_

The Winchester Animal Hospital has medical staffing: Monday through Friday 7am - 6pm and Saturdays 7am - 5pm. If the doctor feels it is necessary, you will be asked to take your pet to the Veterinary Emergency Center for overnight care.

**My pet has had nothing to eat in the last 8 hours. Owner's Initials:** \_\_\_\_\_

**Where can we reach you today?** \_\_\_\_\_

**Estimate** of today's services: \_\_\_\_\_ or [ ] See estimate in file.

**Payment is due when pet is picked up from surgery. Initial** \_\_\_\_\_

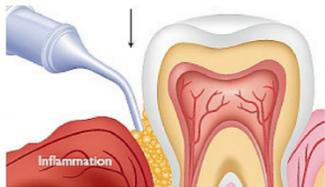
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**If the doctor finds something unexpected, I would like the following steps taken:**

\_\_\_ Do not perform any extra services to my pet.

\_\_\_ You do not need to call me, do what is best for my pet within \$ \_\_\_\_\_

\_\_\_ Call me before performing any other services. # \_\_\_\_\_



**If my pet has unhealthy gums** and an antibiotic treatment medically placed under the gums could help heal the gum and help prevent my pet from losing that tooth, please do the treatment. [ ] YES [ ] NO **Initial** \_\_\_\_\_  
**(The cost for this is \$72.00 no matter how many teeth need to be treated.)**

Signature of Owner \_\_\_\_\_ Date \_\_\_\_\_