SOUTH TYLER ANIMAL CLINIC
5508 OLD JACKSONVILLE HWY
TYLER, TX 75703
903-561-1717
Fax 903-561-5181

AUTHORIZATION FOR DENTAL TREATMENT

Date:_____ **Client:**_____

Patient:_____

Surgical authorization: I authorize and direct the veterinarians and staff of South Tyler Animal Clinic to perform an oral examination, dental cleaning, and dental radiographs on my pet.
Broken or abscessed teeth, fractures, resorptive lesions, and other periodontal problems are often uncovered with the removal of tartar and plaque during teeth cleaning procedures. In case additional problems are detected while your pet is under anesthesia, please indicate how you would like for us to handle any additional findings by **PLACING YOUR INITIALS** in front of one of the following options.

A)_____ Do whatever is needed to give a healthy oral cavity. This may involve radiographs, extractions, periodontal treatments and/or medications.

B)_____ Do not do anything beyond routine dental cleaning at this time. Radiographs are not included for a routine dental. I understand that additional dental work needed may require another anesthetic event at another date.

Dental cleanings require general anesthesia, which carries potential risks to the patient. To help reduce those risks, we recommend blood work prior to the procedure. Our in-house lab enables us to run blood chemistries minutes before anesthetic induction. These tests are similar to those your physician would run if you were undergoing anesthesia. Test results also will serve as future reference values should your pet become ill, or alert the doctor to the presence of diseases that could complicate the procedure.

Preanesthetic Blood Screening.....$68.00

_____ I **Accept Preanesthetic Blood Screen** _____ I **Decline Preanesthetic Blood Screen**

_____ Preanesthetic Blood Screen Done

I consent to the administration and use of anesthesia. I agree to pay in full for all services rendered including those deemed necessary for medical or surgical complications or otherwise unforeseen circumstances. The nature and purpose of the procedures, possible alternative methods of treatment, risks involved, and possibility of complications have been fully explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

_____ _____
Client Signature **Emergency Telephone Number**

_____ _____
Date **Alternate Number**

HomeAgain Microchipping: We recommend that you have your pet **Microchipped** while under anesthesia. This is a simple procedure that provides many benefits such as **24/7 Emergency Medical Care** & **Travel Assistance for Found Pets.** This is a great way of protecting your pet in case they are lost.

Microchip Placement.....$40.20 **Annual HomeAgain Membership Fee.....$19.99**

_____ I Accept Microchipping **_____ I Decline Microchipping**