

Five Oaks Animal Hospital
1991 Hwy 11/55 South
Kinston, NC 28504

DENTAL AUTHORIZATION & CONSENT

Owner's Name: _____ Pet's Name: _____ Sex: _____ Age: _____

Address: _____ Breed: _____ Color: _____

Because your pet will have a general anesthetic, the doctors at Five Oaks Animal Hospital recommend that a Pre-Anesthetic Blood screen be performed. This test helps determine if underlying diseases exist which might add risk to your pet's procedure. While this is not mandatory, we do strongly advise it for all cats and dogs over the age of 7 years.

Yes, please do perform a Pre-Anesthetic blood test on my pet. _____ (initial)

No, do not perform a Pre-Anesthetic blood test on my pet. _____ (initial)

I am the owner or agent of the above pet and have the authority to sign this consent. By signing this, I authorize the following procedure(s) on my pet:

I authorize the use of appropriate anesthetics and other medications, and I understand that hospital support personnel will be assisting in my pet's care. I understand that if dental extractions are necessary due to infection or decay they will be performed using our best judgment.

I understand that during anesthesia, emergency or unforeseen conditions may make it necessary for the doctor to perform additional or different procedure(s) that are in my pet's best interest. I therefore authorize these emergency procedures until I can be contacted.

I have been advised as to the nature of the procedure(s) and the risks involved. My questions have been answered to my satisfaction and I realize the results cannot be guaranteed. I have read and understand this authorization and consent.

Additional Information:

_____ Date

_____ Signature of Owner or Agent

Phone number where you can be reached **TODAY**. (____) _____