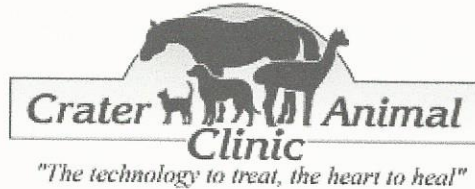


665 E Vilas Rd  
Central Point, OR 97502-3240  
Phone: (541) 779-0951



crateranimalclinic@yahoo.com  
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Fax: (541) 779-6498

## Dentistry Admitting-Authorization Form

**Patient:**

**Client:** Crater Animal Clinic  
(541) 779-0951

Preventative and therapeutic dentistry in cats and dogs consists of placing your pet under general anesthesia and performing a dental prophylaxis where we thoroughly scale (clean) and polish the teeth. Once the teeth are clean, we can examine the different structures of the teeth for pathology (disease process).

We utilize two methods to evaluate the health status of all teeth. The teeth are examined visually and with a dental probe for infection, abscessed roots, mobility, and any other defects or pathology. Also, dental radiographs can be valuable to detect diseased teeth especially in situations where the disease process involves only the tip of the root(s).

We do everything we can to save partially diseased teeth, but often the disease process has progressed beyond the ability to restore oral health. Therefore, the tooth or teeth must be extracted to resolve the infection. Chronic oral or tooth infections can compromise the health and longevity of your pet by causing infection in other areas of the body such as the liver, kidneys, and/or heart. It is best for the health and longevity of your pet to extract teeth that cannot be restored.

Please initial how you would like the doctors and staff at Crater Animal Clinic to proceed:

\_\_\_\_\_ I authorize the doctors & staff at Crater Animal Clinic to perform a dental prophylaxis and oral exam. (anesthesia, oral exam, scaling/polishing, and hospital day stay)

\_\_\_\_\_ I authorize the doctors and staff to perform dental radiographs. (Full mouth radiographs \$75.00)

\_\_\_\_\_ I authorize the doctors and staff to perform any extractions and remedy any oral disease problems as they deem advisable. I do not need to be contacted prior to any procedures. I do not need a treatment plan.

\_\_\_\_\_ I authorize the doctors and staff to perform any extractions and remedy any oral disease problems as they deem advisable. Please CONTACT ME IF if the procedure would make my total invoice exceed \$\_\_\_\_\_ today. I understand that if you attempt to contact me and cannot reach me, my pet will be recovered from anesthesia WITHOUT the needed additional treatment being performed and will have to return for an additional anesthetic procedure at a later date and an additional cost. I am agreeing to be available at my contact number all day.

\_\_\_\_\_ DO NOT PERFORM ANY extractions or treatment other than what has been authorized above WITHOUT CONTACTING me first. I understand that if you cannot reach me, my pet will be recovered from anesthesia WITHOUT the needed additional treatment being performed and will have to return for an additional anesthetic procedure at a later date and an additional cost. I understand that by choosing this option, I am agreeing to be available at my contact number all day.

Additional Services Requested: 1.) \_\_\_\_\_  
2.) \_\_\_\_\_  
3.) \_\_\_\_\_

Do you require a treatment plan for the services being done today? (please initial) YES \_\_\_\_\_ NO \_\_\_\_\_

Telephone number(s) where I can be reached today: 1.) \_\_\_\_\_  
2.) \_\_\_\_\_

I am the owner or agent for the owner of the above animal and have the authority to execute this consent. I hereby authorize the doctors and staff of Crater Animal Clinic to perform the indicated procedures above. I understand that I am responsible for payment of the services at the time my pet is discharged.

\_\_\_\_\_  
Signature of Owner/Authorized Agent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Owner/Authorized Agent