Veterinary Hospitals of Northern Kentucky
www.grantslickvet.com

GRANTS LICK
13169 Alexandria Pike
Butler, KY 41006
859-635-4138
FAX 859-635-6730

PENDLETON COUNTY
204 Park Street
Falmouth, KY 41040
859-654-1031
FAX 859-654-1295

DENTAL AUTHORIZATION-RELEASE FORM

Owner: _____Date _____

Address _____ Phone(s)#:_____

Patient: _____ Patient Date of Birth _____

Breed: _____ Sex:_____ Color: _____

I hereby authorize and direct the veterinarians of Grants Lick and Pendleton County Veterinary Hospitals to perform the dental procedures as deemed advisable for my pet. I understand some risks always exist with anesthesia and/or surgery and I am encouraged to discuss any concerns I have about those risks with the doctor's representative before the procedure(s) is/are initiated.

I understand that the dental care my pet will receive today includes general anesthesia. The teeth will be cleaned with an ultrasonic scaler and polished. Any loose, severely infected or damaged teeth will be extracted at the doctor's discretion. While I accept that all procedures will be performed to the best of the ability of the staff at this facility, I understand veterinary medicine is not an exact science an no guarantees have been made regarding the outcomes of this/these procedure(s).

If further problems are detected while your pet is under anesthesia, how should they be handled?
(Please initial one of the following.)
_____ Perform whatever procedures are needed
_____ Please call me at: _____

If for some reason I am unavailable when you call, please
(Please initial one of the following.)
_____ Perform whatever procedures are needed or
_____ Do only what I have authorized. I understand my pet will have to undergo another anesthetic episode to complete the dental treatment.

I understand that veterinary care during nighttime hours and/or weekends is provided at the discretion of the attending veterinarian and that the continuous presence of personnel may not be provided during these hours. In the event that my pet needs to be hospitalized overnight, I elect to: (Please initial on of the following.)
_____ Have my pet remain in the hospital.
_____ Transfer my pet to a local emergency hospital at my expense
_____ Pick up my pet in which case I accept all possible risks of adverse effects.

On all pets 7 years and older, we do recommend **pre-anesthetic blood test** be performed prior to the administration of anesthesia. These test can help us to detect dehydration, diabetes, kidney disease and liver disease. All of these conditions can contribute to complications in anesthesia and surgery, I understand that these blood test are an added method of safety. Pets of any age may receive pre-anesthetic blood test ii desired. (Please initial one of the following.)

_____ I request pre-anesthetic blood test be performed, there is an additional fee for this.

_____ I decline the pre-anesthetic blood test.

Owners Signature:_____ Date: _____

Phone number(s) where you can be reached: _____