Goosepond Animal Hospital
Dental Authorization Form

Date: 10/04/2012

Owners Name: Practice Client **Pet's Name: Practice Patient**

I AUTHORIZE THE PERFORMANCE OF THE FOLLOWING PROCEDURE(S)

FACTORS THAT LIMIT OUR ABILITY TO DETECT EVERY DENTAL PROBLEM YOUR PET MAY HAVE INCLUDE THE FOLLOWING:

1. **LACK OF PATIENT COOPERATION TO ALLOW PROPER VISUALIZATION, ESPECIALLY OF THE BACK TEETH.**

2. **MANY PERIODONTAL PROBLEMS CAN BE DETECTED ONLY BY PROBING UNDER THE GUMS WITH AN INSTRUMENT.**

3. **DENTAL TARTAR CAN HIDE UNDERLYING CAVITIES OR FRACTURES.**

IF FURTHER PROBLEMS ARE DETECTED WHILE YOUR PET IS UNDER ANESTHESIA, HOW WOULD YOU LIKE US TO HANDLE THEM?

PLEASE CHOOSE ONE OF THE FOLLOWING:

☐ 1. PERFORM WHATEVER PROCEDURES ARE NEEDED.

☐ 2. PLEASE CALL ME; I WILL BE AVAILABLE AT THE FOLLOWING TELEPHONE NUMBER:

NUMBER:

IF FOR SOME REASON I AM UNAVAILABLE WHEN YOU CALL:

☐ A) PERFORM WHATEVER PROCEDURES ARE NEEDED.

☐ B) DO ONLY WHAT I HAVE AUTHORIZED.

☐ 3. DO ONLY WHAT I HAVE AUTHORIZED. I UNDERSTAND MY PET WILL HAVE TO UNDERGO ANOTHER ANESTHETIC EPISODE TO COMPLETE THE DENTAL TREATMENT RECOMMENDED.

OWNERS SIGNATURE