Faust ANIMAL HOSPITAL

3111 E GREENWAY STE 101 | PHOENIX, AZ 85032 | Phone (602) 482-2161 | Fax (602) 482-2370

Dentistry with Anesthesia Authorization

Client Name: ________________________________ Patient Name: ________________________________

Dental disease in dogs and cats may require different therapies depending upon the type and stage of disease present. The veterinarian cannot determine the severity of involvement until the patient is anesthetized and the teeth and gums are thoroughly evaluated. Dental x-rays, and in human dentistry, can uncover many underlying dental problems that can be hidden from view. Often in animals, extractions of broken, infected or diseased teeth may be necessary. In rare cases, the dental procedure may need to be broken down into two separate sessions. This is done for complicated or involved cleanings to reduce the amount of stress and length of time a patient may need to be under anesthesia.

Please choose of the following:

☐ I do not wish to be telephoned prior to additional necessary procedures being performed, such as x-rays, gum or pocket treatments and extractions.

☐ I do wish to be telephoned prior to necessary procedures being performed.

I will be available from **8:00 a.m to 2:00 p.m**. at: ________________________________

NOTE: To permit sterile IV catheter placement, and area of your pet's leg will be shaved.

I hereby authorize the veterinarian(s) of Faust Animal Hospital to perform needed dental services for my pet. I consent to the administration of general anesthesia for my pet as deemed necessary by the veterinarian(s) at Faust Animal Hospital. The nature and purpose of the procedure, the risks involved and possibility of complications have been explained to me. I acknowledge that no guarantee or assurance has been made as to the results that me be obtained. I understand that during the performance of the procedure, unforeseen conditions may rise necessitating and extension or variance in the procedure. I have made a selection above and agree to pay for services rendered due to medical complications or unforeseen circumstances.

Signature of Owner or Agent: ____________________________________ Date: ________________________

Alternate phone number: ___________________________ E-mail address: _____________________________

Hospital representative signature: ________________________________ Date: ________________________