CROSSROADS ANIMAL HOSPITAL
651 HWY 71 W
BASTROP, TX 78602
512-321-0506

PATIENT NAME - PLACE PATIENT LABEL HERE

DENTAL RELEASE FORM

ALL FEES ARE DUE AT THE TIME OF SERVICES RENDERED

Your Dental Cleaning will include: Dental Exam, Pre-Surgery Blood Screen, CBC, Ultrasonic Scaling/Polishing, IV/SQ Fluids, General Anesthesia, Pre Medication(Sedation), Anesthesia Induction & Maintenance, Antibiotics and Courtesy Nail Trim. Now includes full mouth dental radiographs to evaluate tooth roots & check for abnormalities under the gum line.

*** This price does not include any extractions the patient may need, or additional treatments (initial _____)**

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

Factors that limit our ability to detect every dental problem your pet may have with just an oral exam may include:

1. Lack of patient cooperation can impair visualization, especially of 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 proceed?

PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS, PLEASE INITIAL CHOICE:

1. _____ Do whatever is needed to give my pet a healthy oral cavity.
2._____ Please contact me at the phone number listed before doing any additional dental procedures. If I can't be reached by phone while my pet is under anesthesia, then
2A. _____ Perform whatever procedures are needed. 2B. _____ Do only what I have authorized.
3. _____ Do only what I have authorized. I understand additional dental work needed will require another anesthetic episode to complete the dental treatment.

Should an emergency arise calling for procedures in addition to or different from those now contemplated, I further request and authorize whatever emergency treatment is needed. I consent to the administration and use of anesthesia. I agree to pay in full for all services rendered including those deemed necessary for medical or surgical complications or otherwise unforeseen circumstances.

The nature and purpose of the procedures, possible alternative methods of treatment, risks involved and the possibility of complications have been fully explained to me. I acknowledge that no guarantee or assurance had been made as to the results that may be obtained.

Vaccine Requirements for all Dentals: (please initial below for decline)

Rabies:	**[ ] Current**	**[ ] Due**	**Required by state of TX - K9 & FEL (cannot be declined)**				
DHLPP ( )	[ ] Current	[ ] Due	[ ]Accept [ ]Decline*	K9 Special		[ ] Current	[ ] Accept
Bordetella	[ ] Current	[ ] Due	[ ]Accept [ ]Decline*			[ ] Due	[ ] Decline*
FVRCP ( )	[ ] Current	[ ] Due	[ ]Accept [ ]Decline*	FEL Special		[ ] Current	[ ] Accept
FELV ( )	[ ] Current	[ ] Due	[ ]Accept [ ]Decline*			[ ] Due	[ ] Decline*

* I have declined other recommended vaccinations for my pet at this time, acknowledging the risks that may or may not be involved in doing so. _____

Signature:_____ Phone#_____

We cannot guarantee all pets coming in will be free of fleas. If your Pet is found to have fleas upon arrival, they will be given a single dose of Capstar without consent, at your expense.

Staff Initials:_____ Date:_____ Check-In Time:_____

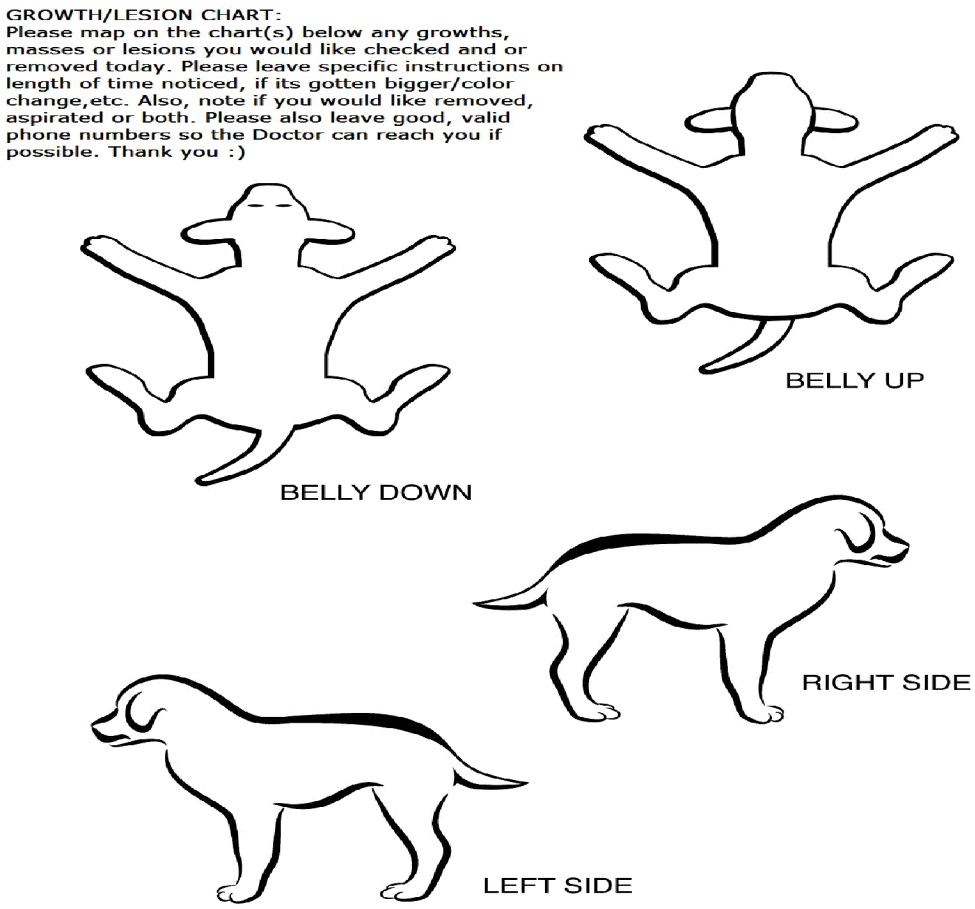
Growth Removal Chart

Please indicate on the chart below where the growth is on your pet that is to be removed. Also, please mark YES or NO if you would like the growth sent to our lab for testing. Please then sign and date this section. Thank you.

Would you like the growth sent to the lab for testing? [ ] YES [ ] NO
Your signature acknowledges you have read and understood the above policies.

X_____ Phone #_____

GROWTH/LESION CHART



NOTES:_____
_____
_____
_____
_____
_____

Thank you for entrusting us with your pet's care. We will do everything we can to honor that trust and provide your pet with the best care possible.

Crossroads Animal Hospital

Staff Initials:_____ Date:_____ Check-In Time:_____