Companion Animal Clinic
201 South Hill Dr.
Blacksburg, Va 24060

Dental Prophylaxis and Procedures
Information and Permission Form

(CURRENTDATE[SHORT])
Client ID: (ID)
(FULLNAME)
(CITY), (STATE) (POSTALCODE)
(PHONENUMBER)

Pet ID: (PATIENTID)
Name: (NAME)
Species: (SPECIES)
Sex: (SEX)
Color: (COLOR)
Birth Date: (BIRTHDATE[SHORT])

Your pet requires some dental procedures. Dental health impacts on the entire well being of your pet. Chronic dental disease can result in chronic pain, loss of appetite, listlessness, gum and heart valve infections, as well as systemic infections. The teeth will be cleaned, polished and fluoride treated. We will thoroughly examine all the teeth and gums for problems that need to be treated. Possible problems include gum disease and recession, root exposure & decayed roots, loose teeth, cavities, fractured teeth, and root canal disease. Frequently we need to extract teeth/roots, fill cavities, or do oral surgery on diseased gums. We treat diseased teeth and gums only as necessary for good dental health. We extract teeth only as necessary and you will probably notice that your pet feels much better once diseased and infected teeth are removed, allowing the mouth to heal.

Although during a routine exam we can assess needed procedures, often we will not know the extent of problems and the treatment needed until we are performing the dental. We will treat problems only as necessary. If unusual problems exist, we will attempt to contact you. If you want only a routine cleaning done and wish to be contacted prior to treating any problems, then you ***MUST BE AVAILABLE BY PHONE BETWEEN 8:30am-2:00pm.*** Please let us know and leave a phone number. If we are unable to reach you, then the veterinarian will treat the problems in the best interest of the pet. Please sign below to indicate that you have read and understand the above.

Permission to do dental work on the above listed pet.

_____
Signature of owner/agent

PLEASE INDICATE IF YOU WANT US TO CONTACT YOU PRIOR TO TREATING ANY PROBLEMS DURING A ROUTINE CLEANING (MUST BE AVAILABLE BETWEEN 8:30AM-2PM)
Yes_____ PHONE_____

No_____ (treat per Doctor's assessment).

Date _____