

Cowesett Animal Hospital



Compassionate care ❖ Lifetime commitment

Dental Treatment Consent Form

Date _____ Patient name _____ Owner _____

Your pet has dental disease that requires general anesthesia to treat and may require tooth extraction(s). While serious complications are extremely rare, they can occur and we want you to be aware of them. Because untreated dental disease always progresses, the risk to your pet from his/her disease is greater than the risk of treatment. Untreated dental disease causes pain, and results in a chronic infection in the mouth that may affect the jaw bone, kidneys, liver and heart.

Some complications that may occur include death from anesthesia (1 in 10,000), damage to tooth and gums, fracture of the jaw bone, damage to the eye, minor change in appearance if canine teeth (fangs) are removed, and possible side effects from antibiotic or pain medications. Please ask if you have any questions about your pet's care.

As the owner/agent of this pet, I give permission to Cowesett Animal Hospital to provide dental treatment. I understand that photographs or dental radiographs may be used for educational purposes. I understand that there may be unforeseen procedures detected that may require additional treatment.

OraVet is a plaque prevention gel. It can only be applied to teeth with no tartar which is accomplished after a dental cleaning. After all the teeth are scaled and polished, OraVet can be applied to decrease the chance of plaque adhering to the teeth and forming tartar. OraVet needs to be applied only once a week. OraVet is only beneficial if your pet will allow you to apply it once a week.

Please Initial:

1. I would like OraVet to be applied to my pet's teeth today.
2. I do not want OraVet applied to my pet's teeth.

*** SEE NEXT PAGE***

Please Initial one of following options:

1. ____ I authorize any treatment needed regardless of cost.
2. ____ I authorize only a dental cleaning of scaling and polish and wish to be called if any extractions and/or other treatment is needed.
3. ____ I authorize scaling, polishing and extractions and treatment up to the limit of my estimate (\$_____). Please call for any additional costs that may arise.

If options 2 or 3 were chosen please initial one of the following:

____ If I cannot be reached at the phone numbers provided, I give permission to Cowesett Animal Hospital to provide any care deemed necessary by the judgment of the Doctor.

____ If I cannot be reached at the phone numbers provided, I **do not** give permission to Cowesett Animal Hospital to perform any additional procedures without my approval. I understand that my pet will have to undergo additional hospitalization and anesthesia to complete needed treatment.

I authorize anesthesia and dental/oral surgery to be performed on my pet as described above. The risks of anesthesia/oral surgery have been explained to me. I understand that a technician and/or doctor is available to answer any questions or concerns that I may have prior to the procedure. While Cowesett Animal Hospital, adheres to recognized standards of care, I am aware that complications may arise. I authorize Cowesett Animal Hospital to perform any diagnostic, treatment or surgical procedures as deemed necessary for medical or surgical complication or otherwise unforeseen circumstances. I fully understand all the risks involved and understand that the technicians and/or doctor will try to minimize such risks.

Signature of pet owner/agent

Date

Phone number(s) I can be reached at