

DeSoto Animal Clinic

Veterinary Medicine & Surgery

Arrive for admission between 8:00am and 8:30 am on _____

Fasting instructions: NO FOOD after 8:00 PM the night prior to anesthesia. Access to water is acceptable.

Please Note: If your pet has external parasites on admission, treatment will be applied at your expense.

DENTAL PROPHY ADMISSION FORM

Date _____

Owner's Name _____ Pet's Name _____

I understand my pet is undergoing general anesthesia for the purpose of scaling and polishing the teeth.

Pre-anesthetic blood testing- \$58.00 Accept Decline

This test can help reveal hidden problems, which could alter or even prohibit anesthesia.

Blood clotting test: \$49.00 Accept Decline

Highly recommended before any invasive surgical procedure. Blood clotting disorders are uncommon, but this test can detect abnormalities before pursuing surgery.

Dental Radiographs-X-rays can reveal tooth root and bone disease, which is not evident on visual exam.

Perform full mouth radiographs. \$80.00-\$120.00.

Perform any necessary dental radiographs at this time. X-rays are \$20.00 per tooth.

Call with estimate.

Tooth Extractions as indicated-Some teeth are so severely diseased that extraction is necessary to control pain and prevent the spread of infection. Extractions range from \$20.00 to \$60.00 a tooth depending on the difficulty.

Perform any necessary extractions at this time.

Call with estimate.

Other Services Requested:

Express Anal Sacs Nail Trim Clean Ears Microchip

What do you feed your pet? _____

When did your pet last eat? _____

When did your pet last drink? _____

Is your pet on heartworm preventative? _____

Is your pet on flea medication? _____

Is your pet on any other medications, dosage and last time given: _____

Permission for Diagnostics and Treatment

Please read before signing.

If we find the need for any additional diagnostic labwork, or x-rays, would you like us to:

perform the procedures contact you with an estimate (ph.# _____)

If your pet requires additional surgical/anesthetic procedures, would you like us to:

perform the procedures contact you with an estimate (ph. # _____)

I permit DeSoto Animal Clinic to treat my pet within the above guidelines.

Signature: _____ Date: _____

Home phone: _____ Wk# _____ Cell# _____

Please indicate your preferred contact number.

Estimate Provided To Client _____ Employee Initial _____

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