

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.

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: \$107.32 Accept Decline

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

Blood clotting test: \$65.89 Accept Decline

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

Electrocardiogram Screen (ECG): \$52.00 Accept Decline

This screen can help detect abnormal electrical impulses and/or changes in the size of the heart.

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

Perform full mouth radiographs. \$138.00-\$178.00.

Perform any necessary dental radiographs at this time. X-rays are \$43.00 per view.

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 \$27.00 to \$70.00 a tooth depending on the difficulty. Some extractions require more extensive periodontal surgery (gingival flap plus bone resection) which is \$117.00.

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? No Yes - Brand? _____

Is your pet on flea/tick medication? No Yes - Brand? _____

Is your pet on any other medication(s)? No Yes If yes, dosage & time last given: _____

Permission for Diagnostics and Treatment. Please read before signing.

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

Perform the procedures if below \$ _____ Contact you with an estimate

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

Perform the procedures Contact you with an estimate

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

Signature: _____ Date: _____

Home #: _____ Cell #: _____ Work #: _____

Please indicate your preferred contact number: _____

Estimate Provided to Client _____ Employee Initial