

# THE CAT HOSPITAL OF ORLANDO

## CONSENT FORM FOR DENTAL PROCEDURE

I, the undersigned owner or agent of the owner of the pet named \_\_\_\_\_  
Certify that **I am** \_\_\_\_ **I am not** \_\_\_\_ (check one) eighteen years of age or over. I have been informed that my pet is in need of preventive or therapeutic dental care and consent to the appropriate procedures described to me by the staff veterinarians at The Cat Hospital of Orlando. These procedures include but are not limited to: 1) dental prophylaxis (routine teeth cleaning and polishing), 2) extractions, 3) gingival flap surgery to close gaps left by extractions, 4) dental radiographs.

I am aware that dental procedures for pets require the use of anesthesia to: 1) maximize visualization of the gums, teeth, and oral cavity, 2) minimize movement and discomfort, and 3) provide for the safety of the pet, doctors, and hospital staff. I understand that some risk always exist with anesthesia and dental procedures and that I am encouraged to discuss any concerns I have about those risks with the attending veterinarian before these procedures are initiated. Should unexpected life-saving emergency care be required and the attending veterinarian is unable to reach me, the staff has my permission to provide such treatment and I agree to pay for such care.

I have been informed that examinations under anesthesia often reveal abnormally loose teeth that fall out or should be extracted to prevent oral discomfort and ongoing infection of surrounding bone. I have also been informed that the loss or removal of one or more unhealthy teeth occasionally allows for an awkward protrusion of the tongue to one side or the other.

**Additional fees will apply for tooth extractions.** \_\_\_\_\_ (please initial)

**I authorize The Cat Hospital of Orlando to run additional lab testing prior to dental procedure if needed** \_\_\_\_\_ (please initial)

Nevertheless, all questions and concerns I have about the recommended dental procedures have been answered to my satisfaction. Should unexpected life-saving emergency care be required and the hospital staff is unable to reach me, the staff **has** \_\_\_\_\_ **does not have** \_\_\_\_\_ (check one) my permission to provide such treatment and I agree to pay for such services.

I understand that an estimate of the fees for the above dental care will be provided to me upon request and that I am encouraged to discuss all fees related to such care before services are rendered. I agree to assume financial responsibility for the fees and provide payment via cash, check, or credit card at the time my pet is discharged.

\_\_\_\_\_  
Signature of Owner or Agent

\_\_\_\_\_  
Date:

Contact Phone Numbers \_\_\_\_\_