



DENTAL RELEASE FORM

PERSONAL INFORMATION

Client's First Name:

Client's Last Name:

Phone Number:

Patient's Name:

Patient's Age:

Procedure:

Date of Procedure : / /

THIS SECTION IS FOR DENTAL PROCEDURES ONLY: *Please read and select the box that applies.*

Dental Extractions:

Tartar and tooth movement can limit assessment during routine exams. Severely diseased teeth may cause pain and infection, affecting major organs. During cleaning, teeth are evaluated and may require extraction or referral to a specialist. Extraction costs vary.

- ☐ I authorize the performance of all medically necessary extractions.
- ☐ Please contact me prior to any extractions. If I am unavailable, extractions are not authorized.
- ☐ I decline dental extractions and prefer to consult a dental specialist for further treatment.

SURGICAL REQUIREMENTS: *Kindly review and check each box to confirm that you have read and agree.*

- ☐ I understand that IV catheter placement is required and will be performed on my pet at an additional cost.
- ☐ I understand that pain medication and antibiotics will be administered to my pet at an additional cost.
- ☐ I understand pre-operative bloodwork is required at an additional cost. *Kindly inform the staff if pre-operative bloodwork has been completed within the past 30 days.*
- ☐ I will purchase an E-collar for my pet at an additional cost. *Please inform the staff if you have an E-collar at home and kindly bring it with you at the time of pickup.*

OPTIONAL PROCEDURES: *Please review and check each box to confirm adding the service to today's visit.*

- ☐ I would like an AKC Reunite microchip implanted for an additional cost.
- ☐ Please perform post-surgical Photobiomodulation Therapy (Laser Therapy) on my pet at an additional cost.
- ☐ Please perform a *complimentary* nail trim on my pet.

PLEASE READ CAREFULLY & SIGN

If your pet is currently taking any medications, please inform us in advance with the name, type, and dosage. Post-operative pain management and antibiotic treatment are determined at the discretion of the doctor and may incur additional charges for medications administered at the clinic or sent home.

As the owner or authorized agent of the above-named pet, I consent to Lake Alfred Animal Hospital performing surgery and related treatments. I understand that unforeseen conditions may arise during the procedure, requiring changes or extensions to the planned treatment. I expect the hospital to exercise reasonable care and professional judgment throughout.

While all procedures will be performed to the best of the staff's professional ability, I understand that no guarantee or warranty is made regarding the outcome. I accept financial responsibility for all services rendered, with payment due at the time of service. *A written estimate is available upon request.*

SIGNATURE OF OWNER OR AGENT:

DATE: / /