ANIMAL CLINIC EAST

1640 E Isaacs Avenue ♦ Walla Walla ♦ WA ♦ 99362

ADMISSION & CONSENT FORM FOR DENTISTRY

Appointment Date _____

Client Name: _____
Client Address: _____
City, State, Zip Code: _____
Phone: _____
Email Address: _____
Email Reminders: Yes ☐ No ☐ *(check one)*

Patient Name: _____
Dog ☐ Cat ☐ Other ☐
Breed _____ Color _____
Spayed ☐ Neutered ☐ Intact ☐
Age: _____ Weight: _____
Microchip#: _____

Daytime Name/Phone Number: ***(if different than above)*** _____

Procedure(s) to be performed today: _____

Medication(s): _____

Known adverse reactions to any medications: _____

1. For our surgery patients under 8 years old, pre-anesthetic blood work is not required but we recommend it to identify "at risk" patients. The risks of anesthesia increase with age, therefore, if your pet is 8 years or older, we do not recommend surgery without pre-anesthetic screening

☐**Yes, I want the blood work for an additional $131** ☐**No, I decline this blood work and am aware of the risks.**

2. Did your pet eat today?..... ☐Yes ☐No

3. Have you noticed any vomiting, diarrhea, and/or coughing during the past 7 days?..... ☐Yes ☐No

4. Does your pet have a history of allergic reactions or difficulty following anesthesia?..... ☐Yes ☐No

5. Is your pet on any additional medication? a) What type? b) How often? _____

6. What time did your pet receive medication today? _____

7. Is your pet treated for fleas? (type and last date given) _____

8. If your pet is ***not*** microchipped, would you like us to implant one today for $54.00? ..... ☐Yes ☐No

9. If the doctor feels it is necessary due to your pet's age/health condition, your pet may be put on IV/SQ fluids.

10. If your pet is not current on recommended and required **vaccinations**, I understand vaccinations will be administered today at the doctor's discretion _____ **(initial)**

11. Are there any questions or concerns you have for the veterinarian? _____

_____

***NOTE**: We are committed to the practice of high-quality medicine; therefore, your pet may be prescribed and you may be charged for additional pain relief medications and/or antibiotics upon discharge. In addition, Xray imaging is performed on all dental patients for a fee of $74.*

Statement of Medical and Financial Responsibility:

I hereby give my consent and accept financial responsibility for the above listed procedure(s) to be performed. Even though pets are given a pre-procedure exam, I understand that there are risks involved in the administration of general anesthesia and in performing all surgeries; therefore, I give permission for the performance of any additional treatments necessary for the welfare of my pet.

I understand that payment is due in full upon my pet's discharge. My method of payment will be:

☐**Check** ☐**Debit or Credit Card** ☐**Cash** ☐**Care Credit Account**

Signature _____ Date _____

Hospital Use Only Updated & Scanned ☐ _____ (initials)