Sherwood Family Pet Clinic – 20900 SW Olds Place Sherwood, OR 97140 – (503) 625-5664

Dr. Robert Merrill, Dr. Courtney Woodside, Dr. Mark Schlimgen, Dr. Leticia Wustenberg, Dr. Christina Sitton, Dr. Kaitlyn Rudie

Dental Release Form

Owner_____ **Pet's Name**_____

Procedure(s)_____ **Preferred Pick Up Time**_____

Best Number Where I Can Be Reached Today_____

Clinic Policy: If your pet is unvaccinated or overdue for vaccines, we will immunize or reschedule the appointment to prevent intra-hospital infection. If your pet cannot receive vaccinations due to health reasons, your pet will be housed in our isolation ward for their protection and for the protection of other pets in the hospital. **There will be a charge for any pet housed in isolation.**
If fleas or flea droppings are found on your pet, we will treat with an appropriate flea medication. **There will be a charge for administered flea medications.**

IV Fluids: These intravenous fluids help ensure safe anesthesia and help patients have better post-operative recovery. All pets undergoing anesthesia with have an IV catheter placed and fluids administered during the procedure.

Pre-Surgical/Anesthetic Blood Screen: This testing will help the veterinarian to identify pre-existing conditions not evident upon the pre-anesthetic examination which may cause complications involving anesthesia. This is recommended for all pets undergoing anesthesia and very strongly recommended for pets over 5 years of age.
____My pet has had a blood screening within the past 30 days. $81.00-$224.00
____**Yes.** I would like a pre-anesthetic blood screening run on my pet.
____**No.** I decline a pre-anesthetic blood screening on my pet.

Tooth Extractions: We try to preserve teeth whenever possible, however extractions are necessary for diseased, broken or unsalvageable teeth. Removal provides relief of pain for your pet and prevents further periodontal disease. Antibiotics, materials and additional anesthesia may also be required for extractions.
Please indicate one of the following:
____Please attempt to contact me with an estimate before proceeding with extractions. Cost Varies. However, if you are unable to contact me, proceed with extractions as necessary.
____Proceed with specific extractions as indicated on the estimate. Attempt to call me for additional dental work (extractions, sealants, etc.)
____Do not extract any teeth unless you are able to contact me. Should your pet need extractions that we were not able to perform, they will have to return at a different date to complete the work needed.

Nail Trim: Trimming toenails under anesthesia is easier and less stressful for your pet.
____**Yes.** $10.50
____**No.**

Cold Laser Therapy: Laser therapy helps relieve pain, decrease inflammation and speed healing of the surgery site. The treatment is given after surgery and before discharge.
____**Yes.** $24.00
____**No.**

Permanent Identification Microchip: A microchip implanted under your pet's skin carries a unique number which can be read with a scanner. This number can be traced back to you so your pet can be reunited should it become lost. We recommend microchips for all pets.
____My pet already has a microchip. $58.00
____**Yes.**
____**No.**

Overnight care at SFPC is unsupervised at times outside of normal business hours. For safety reasons, no continuous IV fluids are given during hours where pets are not under direct supervision.
I certify that I own the above animal, or am responsible for it, and I hereby consent and authorize the Sherwood Family Pet Clinic veterinarians and staff to medicate, treat and hospitalize my animal. I have been advised as to the nature of the procedures or operations and the risks involved and have had the opportunity to have any questions answered. I acknowledge that no assurance or guarantee has been made except reasonable precautions against injury or escape and that risks and probabilities of complications exist in any surgery, anesthesia or medical treatment. I certify that I am the responsible party for the above animal and assume all financial responsibility. **PAYMENT IS DUE IN FULL AT TIME OF PATIENT DISCHARGE.**

Signature_____**Date**_____