DENTAL PROPHY CONSENT

DATE:___________________ OWNER / AGENT:__________________________________

PATIENT:____

PHONE NUMBER:____

PLEASE READ AND CHOOSE ONE OF THE FOLLOWING:

IF A DENTAL PROCEDURE IS BEING PERFORMED PLEASE READ AND CHOOSE ONE OPTION FROM BELOW:

_____I APPROVE EXTRACTIONS TO BE PERFORMED UP TO A COST OF ________ IF DEEMED MEDICALLY NECESSARY BY THE DOCTOR PERFORMING THE PROCEDURE. WITH THIS OPTION I WAIVE MY RIGHT TO BE CONTACTED BY A TEAM MEMBER OF SOUTHEAST VETERINARY HOSPITAL UNLESS THE PROCEDURE DOES NOT COINCIDE WITH THE ABOVE LISTED AMOUNT

- **OR -**

____I APPROVE EXRACTIONS TO BE PERFORMED ONLY IF APPROVED DIRECTLY BY ME AT THE TIME OF THE PROCEDURE. I UNDERSTAND THAT IF I AM NOT ABLE TO BE CONTACTED BY A MEMBER OF SOUTHEAST VETERINARY HOSPITAL THEY WILL NOT EXTRACT ANY TEETH EVEN IF IT IS DEEMED NECESSARY. ANY ADDITIONAL ANESTHESIA OR SURGICAL COSTS NEEDED DUE TO FAILURE TO REACH ME AT THE NUMBER PROVIDED WILL BE AT MY (THE OWNER / AGENT) EXPENSE.

____OTHER:____
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