

Columbus Animal Hospital

2278 39th Ave Columbus, NE 68601
(402) 563-4151

DENTAL ANESTHESIA / PROCEDURE RELEASE FORM

Owner: _____ Phone #: (____) _____

Address: _____ City/State : _____

e-mail: _____

Patient's Name: _____ dog / cat / other (specify) _____

Breed: _____ Sex: _____ Age: _____

Color and/or Markings: _____

I have signed below as the authorized owner or custodian of the animal described above, and hereby give the Doctors at **COLUMBUS ANIMAL HOSPITAL** permission to use anesthesia on this animal. I understand that a certain amount of risk is involved in this anesthetic and surgical/medical procedure. To help insure my pet comes home clean and completely recovered from anesthetic, I understand it will be hospitalized overnight and available for pick-up after 11:00 am on the agreed upon pick-up day.

_____ I authorize the doctors and staff at COLUMBUS ANIMAL HOSPITAL to perform any and all dental extractions that are necessary for the well-being of the animal described above and I will assume full financial responsibility for this.

_____ I would liked to be called prior to any dental extractions or futher diagnostic procedures that may be necessary. I can be reached at this number _____

_____ I authorize the doctors and staff at COLUMBUS ANIMAL HOSPITAL to perform any and all dental extractions that are necessary for the well-being of the animal described above and I will assume full financial responsibility up to this dollar amount _____. If it should exceed this limit, I would like to be called prior to further diagnostic work. I can be reached at _____.

_____ If I am unable to be reached I would like the doctors and staff at COLUMBUS ANIMAL HOSPITAL to do the following: _____

Signed _____

Date _____

Ann Kramer DVM

Jim Kramer DVM

Stephanie Wesely DVM

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