Apex Dog and Cat Dentistry

Specializing in Veterinary Dentistry and Oral Surgery

Donald Beebe, DVM, Diplomate AVDC
Board Certified Specialist in Dentistry & Oral Surgery

Client Information

First Name:	**Last Name:**
Additional Owner(s):	
Mailing Address:	
City: **State:**	**Zip:**
Primary Phone: ( )	**Secondary Phone: ( )**
Email:	**Occupation:**
How did you hear about us? ❒ Personal Veterinarian ❒ VRCC ❒ Friend ❒ Website ❒ Other:	
Referring Veterinarian:	**Referring Hospital:**

Patient Information

Pet's Name:	**Species:** ❒ Canine ❒ Feline ❒ Other	**Birth date:**
Breed:	❒ Male ❒ Female ❒ Neutered ❒ Spayed	**Color:**

Patient Information #2

Pet's Name:	**Species:** ❒ Canine ❒ Feline ❒ Other	**Birth date:**
Breed:	❒ Male ❒ Female ❒ Neutered ❒ Spayed	**Color:**

TREATMENT AUTHORIZATION and INFORMATION/PHOTO RELEASE

I hereby authorize Dr. Beebe and Apex Dog and Cat Dentistry to examine, prescribe for, and treat my pet. If another veterinarian has referred me to this hospital, I understand that they will receive a summary of the care provided in order to ensure that my pet's care can be continued without interruption. I also understand that the identification of a referring veterinarian by me to be my authorization to release records and information to that veterinarian. Case information and/or photos may be used in teaching, forms, continuing education, Web site, veterinary literature, and the like. I authorize the release of case/patient information for such purposes; patient confidentiality (names withheld) will be maintained.

FINANCIAL POLICY

Payment is due as services are rendered. For hospitalized cases, a deposit may be required in advance. The balance will be due upon discharge from the hospital. You may pay by cash, personal check (with proper identification), Care Credit, or accepted credit cards. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory. In the event payment is not made at the time of service, it is our policy to apply a service charge to accounts with a balance over 30 days old. A service fee of 2% of the outstanding balance will be charged to your account monthly if not paid in full. All returned checks will incur a charge of $25.00 and may be referred to the District Attorney for collection.

NAMES OF INDIVIDUALS AUTHORIZED TO PICK UP PATIENT:

____

Name(s):

I understand that I (the owner or agent) am financially responsible) for all charges relating to this patient. I have read and agree to the treatment authorization. I have also read and accept the financial obligations.

______________________________ ____________________

Signature: Date:

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Patient History Form

Pet Name: ____ Date:________________________________

What is your primary concern about your pet?

What medications is your pet taking (list doses/frequency if you know them)?

List of medical problems:

Has your pet previously undergone treatment for dental problems? ❒ Yes ❒ No

Please Describe (Include dates/treatment):

Has your pet had unusual reactions to any medications? ❒ Yes ❒ No

If yes, please list medication(s):

Has your pet had any discharge from the eye/nose? ❒ Yes ❒ No

Has your pet been sneezing excessively? ❒ Yes ❒ No

Does your pet have bad breath? ❒ Yes ❒ No

Does your pet have discolored teeth? ❒ Yes ❒ No

Does your pet have loose teeth? ❒ Yes ❒ No

Does your pet have red or bleeding gums? ❒ Yes ❒ No

Does your pet have fractured or broken teeth? ❒ Yes ❒ No

Does your pet have growths on the gum or tongue? ❒ Yes ❒ No

Does your pet show reluctance to chew hard items? ❒ Yes ❒ No

Did your pet fail to lose baby teeth? ❒ Yes ❒ No

Please check the items your pet chews on:

❒ KONGS ❒ BONES ❒ ROPE TOYS ❒ TENNIS BALLS ❒ GREENIES ❒ NYLON BONES
❒ RAWHIDES ❒ FRISBEES ❒ DOG BISCUITS ❒ ICE CUBES ❒ PIG EARS/COW HOOVES
❒ Other:

Please check the current dental care being used and indicate frequency of use:

❒ Tooth brushing:
❒ Water additive:
❒ Oravet:
❒ Dental Food/Treats:
❒ Oral Rinse:
❒ Other: