

**Texas Veterinary Dental Center  
12810 Fountain Lake Circle  
Stafford, Texas 77477  
281-325-0074**



**RESCUE GROUP NAME:** \_\_\_\_\_  
( 501(c)(3)/non-profit status verified)

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**MAIN CONTACT PERSON TO APPROVE MEDICAL RECOMMENDATIONS:** \_\_\_\_\_  
**CONTACT #:** \_\_\_\_\_

**MAIN CONTACT PERSON FOR BILLING:** \_\_\_\_\_  
**CONTACT #:** \_\_\_\_\_

**FOSTER (if applicable):** \_\_\_\_\_ **FOSTER CONTACT #:** \_\_\_\_\_

**REFERRED BY VETERINARIAN /  
CLINIC/SELF/OTHER:** \_\_\_\_\_

**PATIENT'S NAME:** \_\_\_\_\_ **SPECIES:** \_\_\_\_\_ **BREED:** \_\_\_\_\_

**SEX:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **COLOR:** \_\_\_\_\_

**REASON FOR VISIT** \_\_\_\_\_

Your rescue group was referred to Texas Veterinary Dental Center out of trust and concern that your pet be provided the opportunity to receive advanced veterinary dental care.

By signing below, you hereby authorize Dr. McCoy and/or his associates of the Texas Veterinary Dental Center to examine and treat the described pets listed in your file. You agree to maintain your relationship with your primary veterinarian for health and wellness issues not related to dentistry. You also assume financial responsibility for the care of your pet(s) and understand payment is due at the time of discharge. Permission to release medical history is also granted, unless otherwise stated or revoked.

Signature of Agent for patient: \_\_\_\_\_ Date: \_\_\_\_\_