



CLIENT INFORMATION

Name of Owner: _____

Name of other interested Parties: _____

Address: _____ Apartment Number: _____

City, State: _____ Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PATIENT INFORMATION

Name: _____ Birth date or Age: _____ Species: (canine, feline, other): _____

Breed: _____ Color: _____ Sex: _____ Please circle one: spayed / neutered / intact

Are Vaccinations current? _____ Last veterinary visit: _____

Regular Veterinary Clinic: _____

Regular Veterinarian: _____

Reason for tonight's visit: _____

How were you referred to our hospital? My Veterinarian Previous Visit Friend Sign
 Offsite Event Facebook/Twitter Google Our website Law Enforcement
 Other (specify) _____

Preferred Method of Payment: Cash AMEX M/C Visa Personal Check Care Credit

(There is a \$60 Service Charge on all returned checks.)

PAYMENT IS DUE AT THE TIME OF SERVICE. NO BILLING

Patients hospitalized for treatment must be picked up before 8:00 a.m. the following morning (except Sunday mornings or holidays). **An hourly charge of \$55 will be added for all patients left in the clinic after 8:00 a.m.** Should the patient require further attention after our office closes, he/she should be taken to your regular veterinarian.

I hereby grant authority of the Veterinarians in charge of the care of the patient described above to examine said patient to determine the course of treatment that he/she believes to be in the best interest of the patient. I understand that every effort will be made to discuss recommended treatments, diagnostics, and/or operations before they are performed but that some life saving treatments may be necessary to stabilize the patient long enough to discuss my options. I further authorize digital images of my pet to be used for educational and social media purposes.

(Signature)

(Date)

Check this box if you would like to DECLINE the use of digital images or references of your pet for education and social media