Admission Form

DATE	TIME	CLIENT #	PATIENT #

LAST NAME	FIRST NAME	EMAIL

HOME ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE

PET NAME	SPECIES	BREED	COLOR	SEX: M ❑ F ❑	SPAYED/NEUTERED: YES ❑ NO ❑	AGE

PRIMARY ANIMAL HOSPITAL	PRIMARY VETERINARIAN	HOW DID YOU HEAR ABOUT US? VET INTERNET PHONE BOOK FRIEND PREVIOUS VISIT OTHER:

CURRENTLY UNDER TREATMENT: YES NO	DIAGNOSIS:	MEDICATIONS:

PAYMENT WILL BE MADE BY: ❑ CASH ❑ MC / VISA / AM EX / DISCOVER ❑ CHECK (W/TELECHECK APPROVAL) ❑ CARE CREDIT

Authorization for medical and / or surgical treatment:

I, the undersigned, as owner and/or responsible agent of the animal presented for diagnosis and/or treatment, do hereby authorize the veterinarians of Animal Emergency Centre (and assistants the doctor may designate) to administer treatment as is considered therapeutically and/or diagnostically necessary of the basis of findings during the course of said evaluation. I further consent to the administration of such anesthetics and surgical procedures that are deemed necessary on the treatment of the emergent animal. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

I assume financial responsibility for all charges incurred to the patient. I understand that any estimate rendered by the clinic is an attempt to predict as accurately as possible the costs of services performed. The exact amount of the fees shall depend upon various factors including, but not limited to, unforeseen circumstances that require additional services for the benefit of the animal.

I understand that the patients must be picked up from Animal Emergency Centre by 8 AM (except Saturdays, Sundays and Holidays). Those received Friday may, if necessary, be hospitalized until Monday at 8 AM. After 8 AM I understand that it is my responsibility to take the animal to my regular veterinarian for further treatment if necessary. Any animal not picked up within the specified time frame may be transferred to the local Animal Shelter.

Should the animal require hospitalization, I agree to make a pretreatment deposit in the amount of the estimated cost of treatment. I further understand that all fees are due and payable in full at the time of release of the animal.

X _____

SIGNATURE OF OWNER / RESPONSIBLE AGENT **DATE**

CLIENT # PATIENT #

***** FOR STAFF USE ONLY ***** FOR STAFF USE ONLY ***** FOR STAFF USE ONLY *****

ENTERING COMPLAINT:				
TEMP=	**HR=**	**RESP=**	**MM/CRT=**	**WT=**

DVM SIGNATURE: **DISCHARGING SIGNATURE:**

❑ TAKE DIRECTLY TO YOUR REGULAR VET ❑ RECHECK WITH YOUR VET IN DAYS / WEEKS

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