PETSADENA
ANIMAL HOSPITAL

Owner Information (please print):

Name: _____ Spouse/Other:_____

Address: _____

City:_____ State:_____ Zip:_____

Primary number: (_____)_____ Secondary number: (_____)_____

Work number: (_____)_____

Place of Employment:_____

Drivers License #: _____ State____

Client's D.O.B (for the issuance of control substances) _____

Email Address: _____

How did you hear about us? (please circle one)

Internet Yelp Google Referral_____ (please include name so we can thank them for their referral!)

Shelter Petsadena.com Instagram Facebook

Other_____

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

- I permit and authorize Petsadena Animal Hospital and it's employees, agents, and personnel who are acting on behalf of the Hospital to use my pet's photograph and first name for purposes related to the business of the Hospital, including publicity, marketing, and promotion of the Hospital & it's various websites, including social media. ***Please circle one:*** **YES / NO**
- I request that Petsadena Animal Hospital doctors and team perform the services which are necessary to the examination and medical treatment of the animal(s) presented by me. I am the owner or agent for the owner of the described animal(s) and have authority to execute this consent. Provider is hereinafter understood to mean Petsadena Animal Hospital, its veterinarians, agents, and employees.
- I authorize the veterinarians on duty (and assistants they may designate) to examine the animal(s) and to administer medical treatment or emergency care which is considered therapeutically and/or diagnostically necessary on the basis of the examination findings. I, therefore, hereby consent to and authorize the performance of such procedures as deemed necessary and desirable in the veterinarian's professional judgment.
- I understand that the treatment of the patient(s) will be conducted with due care and in accordance with the prevailing standards of care in veterinary medicine. I certify that no guarantee or assurance has been made as to the results that may be obtained through the course of treatment undertaken by the Provider.
- Accounts over 30 days past due shall pay interest at the maximum legal rate. I agree to pay all attorney fees, interest, collection costs and other costs of litigation incurred in the collection of past due accounts.
- The Provider shall not be responsible for the loss, theft or destruction of any personal property left with my pet(s).
- I understand that a treatment plan may be provided at my request. I also consent to the release of medical information to other authorized veterinary and/or boarding facilities.
- I assume financial responsibility for all charges incurred to the patient for services rendered and understand that full payment is required upon discharge.
- **I authorize any person with possession of the described animal(s) in addition to myself to request veterinary care for the described animal(s) and have the authorization to make medical decisions for the described animal(s) in my absence. In addition, I understand all services/products rendered by that person will be my financial responsibility.**

Signature of Owner/Authorized Agent_____ Date_____