

# WELCOME TO ALL PETS ANIMAL HOSPITAL

OWNER \_\_\_\_\_ SPOUSE/OTHER \_\_\_\_\_

Authorized Owner Representatives or Family Members \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ EMAIL: \_\_\_\_\_

CELL PHONE # \_\_\_\_\_ SPOUSE CELL PHONE # \_\_\_\_\_

EMERGENCY CONTACT & PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SPOUSE/OTHER EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

## Consent for Exam, Treatment and/or Surgery

I am the owner, or a representative of the owner, of the animal presented and have the authority to execute this consent. I authorize and direct the veterinarians at All Pets Animal Hospital (and their designated assistants) to administer authorized treatment as needed on the basis of findings during the course of evaluation: to diagnose, prescribe, sedate, anesthetize, perform therapeutic procedures and/or surgery as their judgment may dictate to be advisable for the patient's well being. I understand I will be advised as to the nature of the procedures and the risks involved. I understand that no warranty or guarantee will be made as to the results or cure.

An estimate of these fees will be provided at my request for the initial assessment and treatment for the animal presented. I realize that actual expenses may differ from the estimate dependent on the patient's condition and length of stay in the hospital. All Pets Animal Hospital will try to contact me if emergency treatment is required. I also understand and will be responsible for expenses incurred in an emergency when I cannot be reached or there is no time to contact me. I will be fully responsible for monitoring the ongoing expenses and will be fully responsible for all expenses incurred through the animal's diagnosis and treatment. A dispensing veterinarian shall notify the owner that some prescription-only drugs and controlled substances may be available at a pharmacy. If your pet should need to stay past our business hours, personnel will not be present for observation of the animal. If you want 24-hour observation you may pick up your pet and transfer to an all night Emergency Animal Clinic.

**ALL FEES ARE EXPECTED TO BE PAID IN FULL UPON COMPLETION OF THE VISIT.  
A DEPOSIT IS REQUIRED IF THE ANIMAL IS BEING HOSPITALIZED.**

Please indicate method of payment:

Cash    Credit/Debit Card    Check with AZ Driver's License-DL# & expiration date: \_\_\_\_\_

In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agrees to pay all costs including said unpaid balance, reasonable collection fee, finance charges, and/or attorneys' fees.

Proof of current vaccines by a licensed veterinarian is required on your first visit. To prevent the spread of infectious disease, all hospitalized patients must be current on all vaccines and free from internal and external parasites. The signature below authorizes this level of preventive care and the appropriate charges will be assessed in the discharge invoice.

How did you find out about us? \_\_\_\_\_

**Owner Signature for pet(s)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Representative Signature for pet(s)** \_\_\_\_\_ **Date** \_\_\_\_\_

*(Please turn over for patient information)*

**ESSENTIAL PET INFORMATION**

<b>PET'S NAME</b>	<b>BREED</b>	<b>SEX</b>	<b>SPAYED OR NEUTERED (yes/no)</b>	<b>COLOR &amp; MARKINGS</b>	<b>DATE OF BIRTH</b>

**Please explain any significant medical history or information we should be aware of on your pets:**