ALTADENA PET HOSPITAL

Primary Care | Emergency | Special Services

Open Seven Days

Thank you for giving us the opportunity to care for your pet. Please take a moment to complete this information sheet so we can create your pet's hospital medical record.

Owner Information:

Owner's Name: _____ Spouse/Other: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Employer's Name & Address: _____

Email Address: _____ Occupation: _____

Previous Veterinarian/ Hospital: _____

Friend/Relative (In Emergency) _____ Phone: _____

Pet Medical History:

Dog: ☐ Cat: ☐ Other: _____

Name: _____ DOB/Age: _____

Breed: _____ Color: _____

Male: ☐ Female: ☐ Altered/Spayed: ☐

Other pertinent information: _____

_____

_____

How did you first hear of our hospital?

☐ Previous Client ☐ Hospital Sign

☐ AAHA Referral ☐ MyAltadenaVet.com

☐ Google Search ☐ Facebook

☐ Yellow Pages ☐ Other: _____

☐ Individual: _____

☐ Previous Client

Driver's license no: _____ State: _____ Exp: _____ DOB: _____

To prevent the spread of infectious diseases and parasites, hospitalized and boarded pets must be current on all vaccines and free of internal and external parasites.

- I authorize the doctor to provide vaccines and parasite control as needed for my pet.
- I request doctors and staff of Altadena Pet Hospital to perform the services, which are necessary for the examination and medical treatment of my pet(s). I am the ☐ owner or ☐ agent for the owner of the described pet(s) and have authority to execute this consent. I understand that a written treatment plan and its associated costs will be provided by the provider* upon my request. I also consent to the release of medical information.
- I authorize veterinarians on duty (and assistant they may designate) to examine the pet(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 hereby, consent to and authorize the performance of such procedures as deemed necessary and desirable in the veterinarian's best judgment.
- I understand that the treatment of the patients(s) will be conducted with due care and in accordance with the prevailing standards of care in veterinary medicine. I further 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 date shall accrue interest at the maximum legal rate. I agree to pay all attorneys' fee, interest, collection costs and other costs not limited to litigation and arbitration in the collection of past due amounts.
- The provider* shall not be responsible for the loss, theft or destruction of any personal property left with my pet(s).
- I assume financial responsibility for all charges incurred on the patient(s) for services rendered and understand that full payment is required upon request.

_____

Signature of Owner or Responsible Agent Date Witness

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED

Please ask a member of the health care team of the provider for a written treatment plan and its potential costs*

2071 NORTH LAKE AVENUE, ALTADENA, CA 91001 TEL: (626) 798 0738

*Provider is hereinafter understood to mean Altadena Pet Hospital, its veterinarians, agents, and employees.

AAHA ACCREDITED The Standard of Veterinary Excellence