



Animal Emergency & Specialty

“Compassionate 24-hour emergency & specialty vet care for your best friend!”

24 - _____

Today's Date: _____

Current Time: _____

PATIENT INTAKE FORM

Client Information

First Name:		Last Name:		Middle Initial:
Street Address:				
City:			State:	Zip:
Home #:	Cell #:		Work #:	
Employer & Job Title:			Email:	
Are you the pet's owner? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, what is your relationship to the owner?				
Owner's Full Name:			Owner's #:	
Is anyone else authorized to pick up/receive information about the pet? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please list the names of authorized persons and their relationship to you:				
Are you a new client? <input type="checkbox"/> Yes <input type="checkbox"/> No		How did you hear about us?		

Pet Information

Pet Name:		Species: <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other:		Age/DOB:
Breed:	Color(s):	Sex:	Spayed/Neutered? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Veterinarian? Clinic:		Doctor:		
Reason for Visit?				

Please carefully review the Treatment Authorization and Acceptance of Financial Responsibility below and sign if you understand and agree with what is written. Please let us know if you have any questions.

Treatment Authorization

I am the owner or an authorized agent for the owner of the above-named pet. I have the authority to make medical decisions related to the pet. By signing this Patient Intake Form, I authorize AES staff to provide care and perform any treatment, including the administration of anesthesia and surgical procedures, they consider reasonable and necessary for the pet. I understand that, with any medical or surgical procedure, there are risks involved, including the risk of death. I acknowledge that no guarantee or assurance is being made as to treatment results.

Acceptance of Financial Responsibility

I understand that payment in full is required at the time of service. AES staff will provide an estimate of fees upon my request. I acknowledge that an estimate is only an approximation; actual fees may vary. If the pet requires hospitalization, I agree to make a deposit in advance and pay the balance when the pet is discharged. If I do not pick up the pet at the date and time specified by AES staff, additional charges will accrue. I recognize that I am responsible for all charges related to the pet, regardless of treatment results. I agree to make payment in cash or by American Express, Visa, MasterCard, Discover, or Care Credit. I am aware that all delinquent accounts will be transferred to a collection agency.

Owner/Agent Signature:	Date:
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