



ADVANCED. COMPASSIONATE. ACCESSIBLE. 24 / 7

NOR CAL VETERINARY EMERGENCY AND SPECIALTY HOSPITAL ++ PATIENT INTAKE FORM ++

Please provide the following information for our records. **Please Print Clearly.**

PERSONAL INFORMATION

Owner/Pet Companion: _____ **Partner/Spouse:** _____

Street Address: _____ **City/State/Zip:** _____

Home Phone: () _____ **Cell:** () _____ **Alt:** () _____

Driver's License #: _____ **Email:** _____

Owner DOB +M/D/Y+: _____

Your DOB is required by state law should we need to prescribe controlled medication

PET INFORMATION

Pet's Name: _____ **Species:** Dog Cat Other: _____

Breed: _____ **Age/DOB:** _____ **Spayed/Neutered:** Y N **Sex:** Male Female

Color/Markings: _____ **Are Vaccines Current?** Y N UNKNOWN

FAMILY VETERINARIAN / REFERRAL INFORMATION

Veterinarian: _____ **Clinic Name:** _____

Do you have medical records with you? Y N

Do you have X-rays with you? Y N

Other Notes: _____

HOW DID YOU HEAR ABOUT NOR CAL?

Primary Care Veterinarian Word of Mouth Advertisement [if yes, where? _____]

Online Search Yelp Other [please explain: _____]

STATEMENT OF OWNERSHIP AND CONSENT: I am the owner and/or agent of the above animal and have the authorization to consent to treatment if and when it is needed. By signing this agreement, I authorize Nor Cal Veterinary Emergency and Specialty Hospital's staff to provide care and perform any treatment, including the administration of anesthesia and surgical procedures they consider reasonable and necessary for my animal, and I consent to any such services. I understand that with any medical or surgical procedure there are always risks involved, including death, and that no warranty or guarantee is being made as to the results or cure.

I understand that I must come in and collect my animal once notified to do so. Additional charges will accrue if my animal is not collected on the day he/she is ready to be released from the hospital. I will be responsible for all charges incurred. I understand that all veterinary services are to be paid for at the time such services are provided. A finance charge of 1.5% [18% per annum] will be charged on all unpaid invoices beginning 30 days from the invoice date. All unpaid and delinquent accounts will be transferred to a collection agency.

Owner/Authorized Caregiver Signature [Required]: _____ **Date:** _____

Additional Comments: _____
