MANDARIN PET EMERGENCY HOSPITAL

Owner/Agent's Name: _____ Date: _____

Address (NO P.O. Box Numbers) _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

Email Address: _____

Pet Name: _____ Color: _____ ◯ Male ◯ Female

◯ Dog ◯ Cat ◯ Other _____ Spayed/Neutered? ◯ Yes ◯ No

Breed: _____ Age: _____ Vaccinations? ◯ Yes ◯ No Time of last meal: _____

Medications (list all): _____ Reactions? ◯ Yes ◯ No

Allergies/Chronic Illness: _____

Vomiting? ◯ Yes ◯ No Number of times: _____ Diarrhea? ◯ Yes ◯ No Number of times: _____

Pet appeared normal when: _____

In the event of an emergency, do you elect CPR and other resuscitation methods for your pet? ◯ Yes ◯ No

Reason for your visit: _____ Regular Vet: _____

Payment is expected at time of service. We do not offer payment arrangements, billing, nor do we hold checks. A deposit is required on all hospitalized pets with balance due at time of discharge.

Method of Payment: _____ D.O.B. _____ DL# _____

Authorization for Medical and/or Surgical Treatment

As the owner/agent, I hereby authorize the doctor on duty (and any technicians designated by the doctor) to administer any treatment deemed medically necessary to sustain life upon initial presentation. I also consent to the administration such anesthetics and surgical procedures as are necessary. I assume full financial responsibility for all charges incurred to the patient, and understand that payment is due upon completion of services. Any animal not called for within 3 days after discharge shall be considered abandoned by me and disposed of by the discretion of the hospital.

ALL INFORMATION IS CONFIDENTIAL AND WILL ONLY BE USED TO PROVIDE QUALITY CARE FOR YOUR PET. PAYMENT IS DUE WHEN SERVICES ARE RENDERED. ALL COLLECTION AND ATTORNEY FEES WILL BE ADDED TO OUTSTANDING BALANCES.

Authorized Signature _____ Date: _____