EVERGREEN
VETERINARY HOSPITAL

Thank you for trusting us with your pet's health! We understand the importance of giving them the best care available, please take a few moments to fill this form out. Thank you!

Client Information		
Name:		Phone:
Spouse/Partner:		Phone:
Address:		
City:	State:	Zip Code:
Email:		
Other Authorized Individuals:		
Phone:		
How did you hear about us:		

Initials **Please read & initial each statement below as acceptance and acknowledgement**

_____ I authorize Evergreen Veterinary Hospital to call & obtain any/all previous medical records for my pet(s).
_____ I agree to keep my pet(s) contained or leashed while in common areas of Evergreen Veterinary Hospital.
_____ I understand that all charges for treatment & services are due in full the day of service/treatment.
_____ I understand that all appointment cancellations must be made at least 24 hrs in advance. Canceling less than 24 hrs prior or not showing for an appointment will result in an appointment cancellation fee.
_____ I understand that no one but myself & my spouse/partner can make medical decisions or authorize treatments for my pet(s).
_____ I understand that by law Washington requires all pets to be vaccinated for Rabies. By acknowledging this statement, I agree to take full responsibility for any legal actions or consequences assigned to me if I choose not to vaccinate my pet(s) for Rabies.
_____ I understand that Evergreen Veterinary Hospital does not accept returns of any preventative care medications or prescription drugs once they leave the hospital.

I have read, fully understand, and agree to the statements above.

Signature of Owner:_____ Date: _____

Patient Information (Additional Pets on back)		
Name:	Species: Dog Cat	
Breed:	Color:	DOB:
Sex:	Neutered/Spayed:	

Previous Clinic(s) you have visited with your pet(s):
_____

Authorization

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet(s). I assume full responsibility for all charges incurred for the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required dependant on treatment cost.

Signature of Owner: _____ Date:_____

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