Companion Animal Hospital, LLC

306 Poplar View Parkway
Collierville, TN 38017
(901)854-9700

PATIENT & CLIENT INFORMATION SHEET

PATIENT INFORMATION

Pet's name: ____________________________ Sex: ☐ Male ☐ Female Neutered or spayed? ☐ Yes ☐ No

Species: ☐ Dog ☐ Cat ☐ Other ______________________________________
Pet's Date of Birth (Month/Day/Year)_____/_____/_____ Breed___________________________ Color______________________

Does your pet have any allergies, special medications, or health problems we should know about? ☐ Yes ☐ No
If yes, what? ___________________________

Has veterinary medical insurance? ☐ Yes ☐ No If yes, name of carrier? _____________________________

Pet's name: ____________________________ Sex: ☐ Male ☐ Female Neutered or spayed? ☐ Yes ☐ No

Species: ☐ Dog ☐ Cat ☐ Other ______________________________________
Pet's Date of Birth (Month/Day/Year)_____/_____/_____ Breed___________________________ Color______________________

Does your pet have any allergies, special medications, or health problems we should know about? ☐ Yes ☐ No
If yes, what? __________________________

Has veterinary medical insurance? ☐ Yes ☐ No If yes, name of carrier? _____________________________

CLIENT INFORMATION

First name _____________________________________ Last name ____

Spouse first name _____________________________ Spouse last name ____

Address____________________________________ City__________________________ State__________ Zip______________

Home phone (______)______________ Work phone (_____)_______________ Ext_______ Cell (_____)_________________

Best phone # to be contacted during normal business hours (____) ____________________

E-mail address ____ Employer ____

Our pet(s) is a: ☐ Member of our family ☐ Child's pet ☐ Backyard pet

Would you like to be present during treatment of your pet? ☐ Yes ☐ No

How did you become aware of Companion Animal Hospital, LLC?

☐ Referred by friend. Whom may we thank? ____

☐ Referred by veterinarian Whom may we thank? ____

☐ Drove by ☐ Brochure ☐ Previous client ☐ Direct Mailing ☐ Internet ☐ Yellow pages

We appreciate payment when services are rendered. For your convenience, we accept cash, check, MasterCard, Visa, Discover, American Express, and CareCredit. I verify that all the information provided is accurate.

Signed____ Date_________________________________

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CONSENT FORM FOR TREATMENT AND/OR ADMISSION

I, the undersigned owner of, agent of the owner of, or Good Samaritan responsible for seeking veterinary care for the pet identified above, certify that **I am** _____ **I am not** _____ (check one) eighteen years of age or over. I consent to the examination of this pet by staff veterinarians at Companion Animal Hospital, LLC. I also agree that after consultation with me, the hospital's doctors may prescribe medication for, treat, hospitalize, sedate, anesthetize, and/or perform surgery on my pet. I understand that some risks always exist with anesthesia and/or surgery and that I am encouraged to discuss any concerns I have about those risks with the attending veterinarian before the procedure is initiated. Should unexpected life-saving emergency care be required and the attending veterinarian is unable to reach me, the hospital staff has my permission to provide such treatment, and I agree to pay for such care.

I understand that an estimate of the fees for veterinary services will be provided to me and that I am encouraged to discuss all fees related to such care before services are rendered and during my pet's ongoing medical treatment. If my pet is hospitalized, I agree to pay a deposit of 50% of the estimated fees. I agree to assume financial responsibility for the remaining fees and will provide payment via cash, credit card, or check at the time my pet is discharged from the hospital. In the event my pet is hospitalized for more than forty-eight hours and the attending doctor is unable to reach me, I understand it is my responsibility to call the hospital at least every forty-eight hours to inquire as to the medical status of my pet and the fees incurred for medical services up to that day. I agree to pay a monthly billing and financing fee equal to 1.5% of any unpaid balance. I understand that there will be a fee of $27.00 for any check returned for non-payment.

I understand that veterinary care during nighttime hours and/or weekends is provided at the discretion of the attending veterinarian. Continuous presence of personnel will not be provided during these hours.

I further agree that I, or an authorized agent of mine, will pick up my pet and pay for all accrued charges within five days of receiving written or oral notification that my pet is ready to be released from the hospital. Such notice will be given at the address maintained on the hospital's patient/client record. I agree that if I fail to comply with this policy, this practice may handle this abandonment in a manner that is in the best interests of the pet and the hospital.

____   ___________________
Signature of Owner or Agent   Date

____   ___________________
Signature of Parent or Legal Guardian   Date
(if owner/agent less than 18 years of age)