341 Broadway St, Eagle, CO 81631
970-328-7085

Thank you for giving us the opportunity to care for your pet(s). So that we may become better acquainted, please fill out the following:

Client Information

Name: _____ Spouse/Co-Owner's Name: _____

Home Address:_____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Spouse/Co-Owner Phone: _____

Place of Employment: _____ Preferred Method of Contact: _____

Email Address: _____

How did you become aware of our clinic? Drove By_____ Yellow Pages _____ Website _____ Yelp _____

Personal Recommendation: (Whom may we thank?)_____

Pet Information

1st Pet: Name: _____ Breed:_____ DOB:_____

Color: _____ Sex: _____ Is your pet Spayed/Neutered? _____

2nd Pet: Name: _____ Breed:_____ DOB:_____

Color: _____ Sex: _____ Is your pet Spayed/Neutered? _____

3rd Pet: Name: _____ Breed:_____ DOB:_____

Color: _____ Sex: _____ Is your pet Spayed/Neutered? _____

What do you feed your pet? _____

Any serious illnesses or surgeries? _____

Any reactions to vaccines or medications? _____

Is your pet on any special medications, diets, or supplements? _____

When was your last veterinary visit? _____What Hospital?_____

OVER FOR NEXT PAGE

We want to provide excellent customer service, high-quality patient care, and strive to meet and exceed your expectations. The following are important topics and we'd like to be proactive in your wishes. Please don't hesitate to inquire for further explanation or if you have any questions!

We are not a 24-hour facility, and on occasion there may be pets in the facility in the absence of personnel. Our hospital is equipped with smoke detectors. Your pet's doctor will discuss options for overnight care and monitoring when appropriate. **Initial: _____**

Our hospital utilizes a 3rd party to help remind you about your pet's current medical needs such as vaccines due. This agency will not provide your personal information to any other party. Please notify us if we do not have permission to send reminders to you. **Initial: _____**

We love to share veterinary success stories, testimonials, and photos. Please notify us if you wish to prohibit us from using your pet's photo and/or testimonial for training, educational, and/or marketing purposes. There is no expectation of financial compensation and your full name will not be used. **Initial: _____**

Many drugs that have been approved for use in humans and/or some animals have also been proven to be safe and effective in species for which the drugs are not labeled. Our veterinarians, often by necessity, must recommend, administer, and prescribe drugs that are considered extra-label. I authorize my pet's veterinarian to use extra-label drugs. **Initial: _____**

I authorize the release of my pet's vaccination status to grooming, boarding, day care, and veterinary facilities without the additional consent. In the event you've notified us your pet is covered by veterinary pet insurance, we will send medical records when requested. Our hospital will contact you for permission if copies or summaries of the sent records are requested. **Initial: _____**

I authorize the veterinarian to examine, prescribe for, and treat my animal(s). I assume responsibility for all charges incurred in the care of the animal. I also understand that these charges will be *paid in full* at the time of release and that a *deposit will be required for surgical procedures*. In cases of extensive medical or surgical procedures, when full payment may be difficult at discharge, we take all major credit cards and Care Credit. We will gladly prepare a written estimate here in the clinic if you desire (please ask your technicians.) **Initial: _____**

In the event payment is not made in full, all unpaid balances over 30 days old will be subject to monthly interest of 1.5% (APR 18%), regardless of payments being made on the account. An outstanding balance equal to or greater than 60 days with no payment, will be referred to a collection agency. A client whose account is in collections will be dismissed from the care of our practice. All clients that submit full payment for their collection balance will be able to return to our practice. I agree to pay all collection costs including, but not limited to: attorney fees, court costs, and collection agency fees. **Initial: _____**

There will be a $30.00 service charged for any check returned unpaid. **Initial: _____**

To prevent the spread of infectious disease, all hospitalized and boarded patients must be current on all vaccines and be free from internal and external parasites. **Initial: _____**

By signing this document, you have authorized that you have read and understand all of the above information. Thank you.

Signature:_____Date:_____