



24/7 ANIMAL EMERGENCY + SPECIALTY CARE

Thank you for giving us the opportunity to care for your pet. So that we may become better acquainted please provide the following:

CLIENT INFORMATION

Name:
Street Address:
City: State: Zip:
Home Phone: Email:
Cell Phone: How did you hear about us?
Have you been here before?
Primary Veterinary Hospital / Clinic and Doctor:

PET INFORMATION

Pet's Name: Species:
Breed: Age: Color:
Sex: Spayed? Is your pet current on vaccinations?
Neutered? What do you feed your pet?

Payment Information

Please check method of payment for today's visit:
Cash Credit Card Debit Card Check
CareCredit

Authorization For Emergency Care/ Critical Care Treatment

I, the owner or agent of hereby understand, consent and authorize the performance of emergency treatment by the staff Animerge, P.C.

I understand the use of appropriate medications as needed for the critical care of my pet. I further understand that during the course of the procedure(s), unforeseen conditions may arise that may necessitate the performance of additional procedures. I realized that results can not be guaranteed.

I assume financial responsibility for all charges incurred for my pet's care and I understand that all services must be paid for at the time of service.

Client / Agent Signature: Date:

Emergency Phone Number: