Colma Animal Hospital
1232 El Camino Real
Colma, CA 94016

Thank you for the opportunity to care for your pet. Please take a moment to complete this information sheet for the creation of your pet's hospital record.

Owner Information:

Owner's Name_____ Spouse/Other:_____

Address: _____

City: _____ State:_____ Zip:_____

Home Ph: _____ Work Ph:_____ Cell/Other Ph: _____

E-mail Address: _____

Employer's Name/Address: _____

Animal Medical History:

Dog ❑ Cat ❑ DOB/Age: _____

Name: _____

Breed: _____

Male ❑ Female ❑ Altered/spayed ❑

Other pertinent information? _____

_____

How did you first hear of our hospital?

❑ Referring veterinarian: _____

Hospital: _____

❑ Individual: _____

❑ Yellow Pages

❑ Hospital sign

❑ Other: _____

Driver's license no.: _____ **State:** _____ **Exp:** _____

- **I request that Colma Animal Hospital's doctors and stafff perform the services which are necessary to the examination and medical treatment of the animal(s) presented by me. I am the owner or agent for the described animal(s) and have authority to execute this consent. Provider is hereinafter understood to mean Colma Animal Hospital, its veterinarians, agents, and employees.**

- I authorize the veterinarians on duty (and assistant that they may designate) to examine the animal(s) and to administer medical treatment or emergency care which is considered therapeutically and/or diagnostically necessary on the basis of the examination findings. I, therefore, hereby consent to and authorize the performance of such procedures as deemed necessary and desirable in the veterinarian's professional judgment.

- I understand that the treatment of patients(s) will be conducted with due care and in accordance with the prevailing standards of care in veterinary medicine. I certify that no guarantte or assurance has been made as to the result that may be obtained through the course of treatment undertaken by the Provider.

- **Accounts over 30 days past due shall pay interest at the maximum legal rate. I agree to pay all attorney's fees, interest, collection costs, and other costs of litigation incurred in the collection of past due accounts.**

- The Provider shall not be responsible for the loss, theft or destruction of any personal property left with my pet(s).
- I understand that a written estimate for charges will be provided at my request. I also consent to the release of medical information

- I assume financial responsibility for all charges incurred to the patient for services rendered and understand that full payment is required upon request.

_____

Signature of Owner or Responsible Agent Date Witness

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

Please ask a member of our Healthcare Team for a written estimate of potential costs.