



HOSPITAL USE ONLY	Wt:
	Room#:
	Time:

Patient Intake Form

Client Information

First Name:	Last Name:	M.I.:	Add'l Owner(s):
Mailing Address:			
City:	State:	ZIP:	
Home Phone:	Work Phone:	Cell Phone:	
E-mail:	Employer:		
How did you hear about us?	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Walk-In	<input type="checkbox"/> Friend — Their Name <input type="checkbox"/> Other
Referring Veterinarian:	Family Veterinarian (if different):		

Patient Information

Pet's Name:	Species:	<input type="checkbox"/> Canine	<input type="checkbox"/> Feline	<input type="checkbox"/> Other
Breed:	M <input type="checkbox"/>	Neutered <input type="checkbox"/>	Color:	Birthdate or Age:
	F <input type="checkbox"/>	Spayed <input type="checkbox"/>		
Initial Presenting Problem:				

TREATMENT AUTHORIZATION and INFORMATION/PHOTO RELEASE

I hereby authorize VRCC practices to perform medical and initial diagnostic/surgical procedures on my pet as required for diagnosis and treatment. I understand that I can terminate treatment at any time by contacting the doctors and assistants.

If I have been referred to this hospital by another veterinarian, I understand that they will require a summary of the care and treatment provided by the VRCC practices in order to ensure that my pet's care can be continued without interruption. I also understand that VRCC considers the identification of a referring veterinarian by me to be my authorization to release records and information to that veterinarian.

We are leaders and teachers in the veterinary medical field, thus case information and/or photos may be used in teaching, forms, continuing education, Web site, veterinary literature, and the like. I authorize the release of case/patient information for such purposes; patient confidentiality (names withheld) will be maintained.

In the event I sell this pet to another owner, I authorize release of medical information to the new owner, should they request it.

FINANCIAL POLICY

Payment is due as services are rendered. For hospitalized cases, a deposit is required in advance. The balance is due upon discharge from the hospital. You may pay by cash, personal check (with proper identification), or accepted credit cards. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory.

In the event payment is not made at the time of service, it is our policy to apply a service charge to accounts with a balance over 30 days old. A service fee of \$3.00 and 1.5% of the outstanding balance will be charged to your account monthly if not paid in full.

All returned checks will incur a charge of \$25.00 and may be referred to the District Attorney for collection.

NAMES OF INDIVIDUALS AUTHORIZED TO PICK UP PATIENT FROM VRCC:

Name: _____ Name(s): _____

I understand that I (the owner or agent) am financially responsible to the applicable VRCC practice(s) for all charges relating to this patient. I have read and agree to the treatment authorization. I have also read and accept the financial obligations.

Signature: _____ Date: _____