TOWN CENTER
ANIMAL HOSPITAL

CLIENT INFORMATION

NAME: _____

LAST, FIRST, M.I.

SPOUSE/PARTNER NAME: _____

LAST, FIRST, M.I.

HOW DID YOU HEAR ABOUT US: _____

IF INTERNET (CRAIGSLIST, FACEBOOK, GOOGLE, WEBSITE, YAHOO, YELP, YELLOW PAGES, ETC)

ADDRESS: _____

PLEASE CIRCLE (AVE, BLVD, CT, CIR, DR, LN, PL, RD, ST) APT OR UNIT #_____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: HOME: _____-_____-_____ CELL #: _____-_____-_____

EMAIL: _____

EMPLOYER: _____ OCCUPATION/TITLE: _____

WORK: _____-_____-_____ SPOUSE CELL #: _____-_____-_____

3565 SOUTH TOWN CENTER DR. LAS VEGAS, NV 89135 ~ PHONE (702) 262-1300
WWW.TOWNCENTERVET.COM

CONSULTATIONS ARE BY APPOINTMENT.
TO SCHEDULE AN APPOINTMENT, CALL 702-262-1300
HOURS: MON.-FRI. 7AM – 8PM, SAT. 8AM –5 PM, SUN 9AM-4 PM
PAYMENT IN FULL IS EXPECTED UPON RELEASE FROM THE HOSPITAL.
WRITTEN ESTIMATES WILL BE PROVIDED UPON REQUEST.

SEE PAGE 2 (MEDICAL RELEASE)

TOWN CENTER
ANIMAL HOSPITAL

MEDICAL RELEASE

CLIENT NAME: _____
LAST, FIRST, M.I.

PET'S NAME: _____ SPECIES: _____ BIRTH DATE (AGE): _____

GENDER: (CIRCLE) FEMALE SPAYED FEMALE MALE NEUTERED MALE

BREED: _____ COLOR: _____

CASE HISTORY

PRIOR VET/ANIMAL HOSPITAL/CLINIC: _____PHONE: _____

LAST DATE OF (ESTIMATE IF NECESSARY) -VACCINATIONS: _____ FECAL: _____

CURRENT MEDICATIONS: _____ DIET: _____

ALLERGIES OR LONG TERM MEDICAL PROBLEMS: _____

OTHER PERTINENT HISTORY: _____

MICROCHIP: YES NO TYPE_____

PET INSURANCE: YES NO TYPE_____

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 Town Center Animal Hospital. 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 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 available 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 assume financial responsibility of 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 greater 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 further agree that I, or an authorized agent of mine, will pick up my pet and pay for all accrued charges within ten 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