

Farmington Valley Veterinary Emergency Hospital

9 Avonwood Road, Avon, CT 0600 • Phone: (860) 674-1886 • Fax: (860) 674-8314



CLIENT INFORMATION

Pet owner's full name: Mr. Ms. Mrs. _____

Spouse / Partner / co-owner: _____

Address: _____

City & State: _____ Zip Code: _____

Telephone numbers: Home:(____)_____ Cellular:(____)_____

Employer: Work Phone:(____)_____

Additional Phone:(____)_____

Email address: _____

Are you a member of the Military? Yes No Branch _____

Please indicate how you heard about us. (circle all that apply)

Saw sign Yellow Pages Brochure Prior visit

Referred by veterinarian (who?): _____

Friend (who? We would like to thank them) _____

News Paper ad or article (which paper) _____

Other: _____

PATIENT INFORMATION

Pet's name: Breed: Age: _____

Sex: M F Neutered: Yes No

How long have you owned your pet? Are there any known medical conditions? _____

Current medications: _____

What type and brand of food is your pet currently on? _____

Name of Veterinary Hospital to be faxed: _____

Veterinary Address: _____

Veterinary telephone number (____)_____ Fax number:(____)_____

Payment in full is required at the time that services are rendered, an estimate for the cost of services will be provided. If your pet needs to be hospitalized, a 50% deposit of the high end of the estimate will be required at that time. Further deposits may be required during the course of hospitalization. All fees must be paid in full when your pet leaves the hospital.

I am the owner or authorized agent for the owner of the animal being presented. I authorize the Farmington Valley Veterinary Emergency Hospital to examine and render immediate life saving treatment necessary. I understand that no guarantee is made regarding the outcome of any diagnostics or treatment performed. I understand that I have the right to decline any of the diagnostic or treatment recommended by the attending veterinarian. I understand that I am making an informed financial commitment for the care of my pet and agree to assume full financial responsibility for all fees incurred by treatment, regardless of the outcome. I understand that if I default on payment that I agree to pay all fees associated with collection of the debt. I understand that there is a monthly billing fee of 1.5% or \$25.00 whichever is greater.

Signature of owner/ responsible agent: _____

Client Number Assigned: _____

Employee Initials Date _____

In the event that my pet is admitted into the hospital, I want or do not want life saving efforts be made in the event of respiratory or cardiac arrest and understand that the fee for these efforts no matter what the out come is an additional \$500.00 to the original estimate.

Signature of owner/ Responsible agent: _____

Employee witness signature: _____