ROUND TOP
ANIMAL HOSPITAL

OWNER INFORMATION

Authorized Owner **is the person responsible for making medical decisions for the patient. If you are not the authorized owner please notify the receptionist.**

Authorized Owner_____ Last four of SS#:_____

Physical Address:_____

City/Town_____ Sate_____ Zip_____

Mailing Address (if different then physical) :_____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Work: (_____) _____ - _____

Spouse or Co-Owner: _____Spouse/Co-Owner Phone:_____

Email Address:_____@_____

Name of additional authorized party/parties authorized to release information regarding patient:

Name:_____Phone:_____

Name:_____Phone:_____

I authorize above named parties to release information regarding my patient(s): signature of owner (primary account holder) I fully understand that if I wish to change/remove parties authorized to use my account that it is my responsibility to notify us in writing as soon as possible, and that I am responsible for all charges to my account by authorized parties up to and including all charges prior to receipt of written notification.

Treatment Authorization

I HEREBY AUTHORIZE THE VETERINARIAN TO EXAMINE, PRESCRIBE FOR, OR TREAT THE LISTED PET.

Signature:_____Date:_____

Payment Authorization

I ASSUME RESPONSIBILITY FOR ALL CHARGES INCURRED IN THE CARE OF THIS ANIMAL. I ALSO UNDERSTAND THAT THESE CHARGES WILL BE PAID AT THE TIME OF THE VISIT AND A DEPOSIT IS REQUIRED IF THE ANIMAL IS HOSPITALIZED.

Signature:_____Date:_____

PET INFORMATION

Name of pet:_____ ( ) Dog ( ) Cat ( ) Other

Breed:_____ Color:_____ DOB: _____-_____-_____

( ) Male ( ) Neutered ( ) Female ( ) Spayed

Vaccination History (Date and type of vaccine):_____

_____

Pet's Current medication(s):_____

Does your pet have any allergies?:_____

Previous Veterinarian (Clinic and/or Doctors)
Name:_____

Address:_____

Phone Number:_____

May we request your pet's medication/vaccination history for our records?_____