



1705 W. 10th Ave, Broomfield, CO 80020
303-466-8888

Last Name _____ First Name _____ Spouse's Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Number _____

Employer _____ City _____ Work Phone _____

Spouse's Employer _____ City _____ Work Phone _____

Driver's License# _____ Social Security# _____

Email Address _____

(The Animal Doctor will not share your email address with anyone. It will only be used to send reminders of your pet's medical needs, Veterinary updates and our newsletter.)

Who can we thank for referring you to The Animal Doctor? _____

Please indicate your choice of payment. Cash Check Credit Card

ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED

I hereby authorize The Animal Doctor to examine, prescribe for or treat the pet(s) described below. I also consent to the administration of such sedatives or anesthetics as are deemed necessary for appropriate treatment. I agree to pay for all services rendered at the time the pet is discharged from the hospital or when service is discontinued. Methods of payment are limited to *Cash, Personal Check, Visa, MasterCard, Discover, American Express, CareCredit or Citi Health Card*. All late payments are charged a bookkeeping fee of 1.5% or \$5.00, whichever is greater, Collection accounts are required to pay all court and attorney fees.

I certify that I have read and understand this consent form.

Signature of owner or responsible agent _____ Date _____

PATIENT INFORMATION

Pets Names:	1 _____	2 _____	3 _____
Breed:	_____	_____	_____
Color:	_____	_____	_____
Date of Birth:	_____	_____	_____
Sex:	_____	_____	_____
Spay/Neutered?	_____	_____	_____
Heartworm Prevention:	_____	_____	_____
Travels outside of Colorado:	_____	_____	_____
Major problems/Allergies:	_____	_____	_____
Current medications:	_____	_____	_____
Special Diet:	_____	_____	_____