

Animal Medical Center
P. O. Box 255
4012 S. Santa Fe
Chanute, Ks. 66720
(620) 431-0110

NAME: _____ PHONE #: _____
ADDRESS: _____ CITY/STATE/ZIP: _____
EMPLOYER: _____ EMPLOYER PHONE #: _____
SOC. SEC. #: _____ SPOUSE SS #: _____
SPOUSE NAME: _____ SPOUSE EMPL. #: _____
SPOUSE EMPLOYER: _____ COUNTY OF RESIDENCE: _____
REFERRAL: _____ EMAIL ADDRESS _____

I certify that I own the described animal(s) and do hereby consent and authorize the ANIMAL MEDICAL CENTER, and its staff to treat and/or hospitalize my pet, and to administer vaccination, medications, tests, surgical procedures, anesthesia or treatment that the doctors deem necessary for the health, safety or well-being of the described animal(s) while it is under their care and supervision.

If my pet should injure itself in an escape attempt, refuse food, soil it, become ill or die while in the hospital, I will hold the ANIMAL MEDICAL CENTER and staff free of any responsibility and/or liability in the absence of gross negligence.

I further realize that I am responsible for payment for the procedures and treatments in full at the time the animal is discharged. If I neglect to pick up the animal within five (5) days of written notice that it is ready for release and mailed to the above address, you may assume that the pet is abandoned. You are then authorized to dispose of it as you see fit. Abandonment does not release me of my obligation for the bill.

**_____ I AGREE TO PAY FOR TODAY'S SERVICES IN FULL UPON RELEASE-IF
ARRANGEMENTS ARE NEEDED-MUST DISCUSS WITH PROPER AUTHORITY
BEFORE SERVICES**

I further agree that in the case of non-payment, a finance charge of 1.5% per month (18% per annum) will be charge and that any collection fees or attorney fees will be paid by me.

OWNER: _____ DATE: _____

SPOUSE: _____ DATE: _____

AMCCF

PLEASE CONTINUE ON REVERSE SIDE

Thank you for choosing our hospital to care for your pets! We look forward to serving you and your pets, and we would appreciate some background information.

<u>CANINE</u>		<u>FELINE</u>	
Pet Name _____	Pet Name _____	Pet Name _____	Pet Name _____
Breed _____	Breed _____	Breed _____	Breed _____
Sex _____	Sex _____	Sex _____	Sex _____
FE/SPAYED/M/NEUTERED _____		FE/SPAYED/M/NEUTERED _____	
Age _____	Age _____	Age _____	Age _____
Color _____	Color _____	Color _____	Color _____

Please indicate the date of the last vaccination for your pets.

_____	CAN. DISTEMPER	_____	RABIES
_____	PARVO	_____	FEL. LEUKEMIA
_____	CORONA	_____	FEL. DISTEMPER
_____	PARASITE CHECK	_____	CHLAMYDIA
_____	LYME	_____	PARASITE CHECK
_____	KENNEL COUGH		
_____	HEARTWORM TEST		

Is your pet on any medication(s) now? _____yes _____no

If "yes," please specify: _____

Heartworm medication? _____yes _____no

If "yes" which drug? _____

Is your pet seeing any other doctor now? _____

What brings you to our clinic today?

Routine vaccinations/exam: _____

Other problem (please specify): _____

Is your pet currently showing any of the following signs?

_____ Vomiting	_____ Unsteady gait	_____ Lack of energy	_____ Pain
_____ Diarrhea	_____ Lameness	_____ Weakness	_____ Sneezing
_____ Coughing	_____ Lack of appetite		

Does your pet have any allergies? _____yes _____no

Did you bring a fecal sample with you? _____yes _____no

_____ I understand the risks of Anesthesia and do not wish to have any blood work ran at this time.

_____ I would like pre-anesthetic lab work-discussed with the staff what best to run.

AMCCB