



PEND OREILLE VETERINARY SERVICE & PET LODGE

CLIENT REGISTRATION FORM/TREATMENT AUTHORIZATION

Our commitment is giving you and your pet the highest standard of care available

CLIENT'S INFORMATION

NAME (Last, First, MI)			Home Telephone Number (include area code)	
Mailing Address			Work Telephone Number (include area code)	
City	State	Zip Code:	Other (cell, pager, etc) Receive Reminders on Cell Phone? (circle one) Yes No	
Email Address			Emergency Contact (someone you authorize to give consent regarding your pet's immediate care if we are unable to reach you in an emergency situation) Full Name: _____ Phone Number: _____ Relationship to you: _____	
Current Employer: (include Name and Phone Number)				
Driver's License#:		State Issued:		
Social Security #:				

SPOUSE or CO-CLIENT INFORMATION

NAME (Last, First, MI)		Contact Telephone Number(cell, pager, etc)
Current Employer: (include Name and Phone Number)		Work Telephone Number (include area code)

METHOD OF PAYMENT

Cash
 Credit/Debit (we accept Visa/MC/Discover)
 Check
 Care Credit

TELL US ABOUT YOUR PETS

Pet's Name: _____	Pet's Name: _____	
Breed: _____	Breed: _____	
Species: (circle one) Dog Cat Other _____	Species: (circle one) Dog Cat Other _____	
Pet's Name: _____	Pet's Name: _____	
Breed: _____	Breed: _____	
Species: (circle one) Dog Cat Other _____	Species: (circle one) Dog Cat Other _____	

HOW DID YOU HEAR OF US?

Website
 Friend
 Phonebook
 Radio
 Referral
 Other: _____

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT (EMERGENCY OR NON-EMERGENCY)

The undersigned owner or authorized agent of the animal named _____ hereby authorizes Pend Oreille Veterinary Service, a licensed veterinarian and whomever may be designated as its assistants, to administer such treatments and to perform such procedures as are considered therapeutically or diagnostically necessary for the care of said animal, including administration of anesthesia.

In the event that emergency treatment is required, I authorize the veterinary staff and their assistants to perform medical and surgical treatments necessary to preserve the life of the patient until I or one of my authorized agents can be contacted for further authorization.

I understand that no guarantee of successful treatment is made. I accept financial responsibility for the treatment of the above-named pet, and I understand that payment in full is due upon release of the patient or when service is otherwise terminated. I understand that I am entitled to a written estimate of charges upon my request. I will not hold Pend Oreille Veterinary Service liable for any loss. I have read and understand this authorization and agree to all terms, as outlined above.

SIGNATURE OF OWNER _____		DATE OF SIGNATURE _____	
Office Use Only: Staff ID	Date Entered:	Updated:	Updated: Updated: