Windermere Animal Hospital
Dr Reddy, DVM
4415 Front Nine Drive, Suite 900
Cumming, GA 30041
P: 770/887-0676
F: 770/887-0675

Date: ___/___/___
Owner's Name: _____ Pet's Name: _____
Phone Number: _____

Telephone numbers where we can reach you today: _____

Please mark your pets symptoms and explain in the space provided:

Vomiting	Diarrhea	Coughing	Ear Problems	Lameness	Difficult Urination
Sneezing	Ear Problems	Constipation	Skin Problems	Lack of Appetite	Scratching
Lethargy	Other				

Explain: _____
_____

Number of days the problem has persisted: _____
Most recent meal: _____
Type of food eaten: _____
Last normal bowel movement: _____
Last urination: _____
Is your pet on any medication? YES / NO
Explain: _____

List any previously diagnosed conditions: _____
_____

Is your pet allergic to any food or medication? Yes/ No
If yes, please explain: _____
_____

Please check one:
( )treat your pet after examination
OR

( ) Call you with the findings of the examination and estimate of treatment cost PRIOR to treatment.

As owner, or duly authorized agent of the owner, of the above named animal, I hereby consent and authorize the clinic to receive, prescribe, treat or operate on this animal.

The office is to use all reasonable precautions against injury, escape or demise but will not be held liable or responsbile in any manner regarding the care, treatment or safe keeping of the animal. I understand that I am assuming all risks involved in care and treatment for this animal. I consent to administration of anesthesia as deemed necessary by the doctor.

While I accept that all procedures will be performed to the best of the abilities of the staff at this hospital, I understand that no guarantee or warranty has been made regarding the results that may be achieved. I agree to assume financial responsibility for the remaining fees and provide payment via cash, credit card or check at the time my pet is discharged from the hospital. Should unexpected life-saving emergency care be required and the hospital staff is unable to reach me, the staff has my permission to provide such treatment. I hereby agree to pay for such services.

I understand that during the performance of medical, surgical or anethetic procedures, unforeseen conditions may be revealed that necessitate more extensive, costly or different procedures than originally planned. If staff at this veterinary practice are unable to reach me, I hereby consent to and authorize the performance of such procedures as are necessary and desirable in the professional judgement of the attending veterinarian.

All animals must be picked up within three days of the release date. A written notice will be mailed to the address above. Five days after such notice, the animal will be considered abandoned and may be dealt with as the clinic deems appropriate. I understand that abandonment does not relieve me from responsibility of payment for any and all services rendered.

I agree that in the case of nonpayment, a fee of 5% per month (60% per annum) will be charged. PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE PERFORMED.

_____ _____

Signature Date