



Client Information Sheet

Acct #/CCS _____

CLIENT INFORMATION

Name(s): _____ Home phone: _____ Work: _____ Cell: _____

Secondary owner: _____ Work: _____ Cell: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Driver's License# and Issuing state: _____

Have you been to our hospital before? yes no

Referred by: Phone book Television/Radio Family veterinarian Location Family/Friend Internet Other: _____

PATIENT INFORMATION

Pet Name: _____ Species: _____ Breed: _____ Color: _____ Age: _____

Sex: M F Spayed/Neutered: Yes No

Reason for visit today: _____

Current medications: _____ Dose and frequency: _____

Has your pet ever traveled out of state? yes no

Please check any symptoms or problems that you have noticed in your pet:

Behavioral changes Depression Weight Loss Weakness Loss of appetite Lethargy

Gagging Vomiting Diarrhea Breathing problems/coughing/sneezing Seizures Limping

Increased drinking Urination increase/decrease Loss of balance Other _____

PRIMARY CARE VETERINARIAN

Name of Practice: _____ Doctor: _____

AUTHORIZATION

_____ I have received and read WestVet's financial policy form. I acknowledge that payment is due in full at the time of service.

Initial

I am 18 years of age or older and do hereby authorize the veterinarian and technicians to examine my pet and administer treatment as is considered necessary for my pet's condition. A treatment plan of care options will be discussed prior to any treatments. In life-threatening situations, stabilizing care may be instituted upon arrival, but no invasive or diagnostic treatment will be undertaken until it has been discussed with me. I also authorize WestVet to fax or e-mail my pet's medical record to my family veterinarian for the purpose of sharing information only. I understand that WestVet may refuse services for any reason. Any pet left in the hospital for a period of 10 days or more will be considered abandoned under Idaho law.

I hereby release WestVet of all liability in the event of injury, bite, fall or other circumstance that might cause injury while I/my family members am/are a visitor or patron in the hospital. I assume all risks and will take necessary precautions regarding safety in all non-public areas of the hospital for myself and my family.

Signature: _____ Date: _____ Time: _____ AM PM