

Date / /

CLIENT INFORMATION	
Client Name:	Driver's License Number:
Additional Authorized Owner:	
Address:	Client Date of Birth: / /
City:	State: Zip:
Primary Phone: ()	Secondary Phone: ()
Email Address:	
Referring Hospital/Veterinarian:	
Has your pet seen any specialists? If so, who?	
If not referred, how did you hear about us? <input type="checkbox"/> Google <input type="checkbox"/> Yelp <input type="checkbox"/> Sign/ Location <input type="checkbox"/> Other : (please specify below)	

PET INFORMATION	
Pet's Name:	
Age/DOB:	<input type="checkbox"/> Dog <input type="checkbox"/> Cat Breed:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Spayed/ Neutered: <input type="checkbox"/> YES <input type="checkbox"/> NO
Color/ Markings:	
Reason for your visit today:	
We want to make sure that both you and your pet are comfortable. Please indicate any preference you may have:	
<input type="checkbox"/> Prefer to wait in the lobby until the doctor is ready to meet in an exam room	
<input type="checkbox"/> Prefer to wait in an exam room	
<input type="checkbox"/> Unable to sit for long periods	

I am the owner or authorized agent of the pet presented to Advanced Veterinary Internal Medicine. I am of legal age and I consent to the administration of emergency medical treatment for my pet in the best judgment of the veterinarian should the need arise.

 Owner/ Authorized Agent Name (Please Print)

***SIGNATURE WILL BE REQUESTED DURING CHECK-IN FOR YOUR PET'S 1ST APPOINTMENT**

 Client Or Authorized Agent Signature

 Date



PET HEALTH

Date:

Pet Owner's Name:

Pet's Name:

Dog Cat

FOR OFFICE USE ONLY



HAS YOUR PET HAD...

Please check one:

Comments:

Vaccinations within the last year?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
A flea or heartworm preventative?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Any recent surgery or dentistry?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Allergies to any medication or food?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Any recent labwork, x-rays, ECG?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Exposure to any animal with a known illness?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Coughing, shortness of breath, or tiring easily?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Change in appetite or eating habits?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Vomiting, diarrhea, or constipation?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Any recent trauma?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Change in activity level?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Increased thirst or excessive urination?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Blood in urine, stool or other discharge?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Unusual attitude, fainting or seizure?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Swelling, limping, or pain on moving?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Itching, hair loss, or sneezing?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Eye or ear discharge?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	
Any recent travel outside of Southern California?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	

What diet is you pet currently on?

Is your pet: indoor only outdoor only indoor/ outdoor

Please list current medications and dosages:

Additional Comments or Concerns:

PAYMENT INFORMATION


Date:

Pet Owner's Name:

Pet's Name:

Dog Cat

FOR OFFICE USE ONLY



All medical fees must be paid in full at the time of service.

You will be given an estimate for the cost of medical services based on the doctor's initial examination of your pet. We accept the following forms of payment; please indicate how you would like to pay for services today:

- Cash
- Check (valid driver's license required)
- Credit Card (American Express, Discover, Visa, MasterCard)
- CareCredit*

*Care Credit is a line of credit from an independent finance company to cover your medical expenses. It works like a credit card for which you may apply for approval. Processing your application takes only a few minutes and can be done today. If you would like to apply, please ask one of our staff members for an applications

AUTHORIZATION

I understand that I will receive a verbal or written estimate for the services recommended, and that payment for such services is due at the time services are rendered. Should my pet require hospitalization, I will be presented with a written estimate and a deposit will be taken for the full high amount of the estimate. Ongoing hospitalization for patients requiring intensive care will be updated daily with current invoice amount and an updated estimate for the following 24 hours or additional expenses that may be incurred.

I do hereby consent and agree that photographs, videotape, or digital recordings of my pet obtained during hospitalization may be used for the purpose of medical case reports, educational presentations and advertising purposes. Client confidentiality will be maintained.

I have read and fully understand the above authorizations. I am of legal age and assume financial responsibility for all professional fees and agree to pay at the time of services rendered. If for any reason payment is not made, I agree to interest charged annum, necessary attorney's fees, court costs and late fees and any other recovery fees.

I also authorize the transfer of information from my pet's medical record to my primary veterinarian(s).

Owner/ Authorized Agent Name (Please Print)

*SIGNATURE WILL BE REQUESTED DURING CHECK-IN FOR YOUR PET'S 1ST APPONTIMENT

Client Or Authorized Agent Signature

Date

HOSPITAL POLICIES

PAYMENT

- Payment is required at the time of service
- If the patient is hospitalized, a deposit will be taken in the amount of the high end of the signed estimate.
- If the hospitalized stay extends beyond what was originally projected in the initial estimate, a new estimate will be made and additional deposits may be requested.
- When the patient is discharged, the payment for any outstanding balance is required in full. We cannot accept partial payments or post-dated checks.
- If a refund is due, it will be issued in the same way that the deposit was made, and will be issued within 3 days. If payment was made by check, AVIM will issue a refund check approximately 2 weeks.
- We will gladly help you with any pet insurance forms you may have. Please note that we do not bill nor collect payments from pet insurance companies.

PAYMENT METHODS

- AVIM accepts cash, check, Visa, Mastercard, American Express, Discover and CareCredit.
- CareCredit is a medical credit card that can be applied for. This is used just like a normal credit card with a minimum payment due each month to an independent company. The first 6 months are interest free so long as the balance is paid in full by the end of the promotional period. You may apply as a sole applicant or as a co-applicant. ***PLEASE NOTE- all applications must be signed by ANY applicant listed. All applicants must have TWO valid forms of ID that need to accompany a complete application.

VISITING/ UPDATES

- We encourage our clients to visit their pets during hospitalization. We do ask that you call before visiting whenever possible.
- Bearing the animal's condition, visits will take place in the exam rooms.
- Clients are welcome to call in at any time for an update on their pet. If a doctor is unavailable, an update will be given to the client by personnel from the nursing staff that is working directly with their pet.

PERSONAL BELONGINGS

- We understand that many pets have special toys, blankies, beds etc. that they would love to have in the hospital with them. Because of the nature of the hospital setting, please understand that these items have a tendency to get lost amongst the massive amounts of laundry that we go through. If a client leaves a personal belonging with their pet, please understand that they may not get them back at discharge. If the item is truly irreplaceable, please do not leave it in the hospital.

MEDICATION

- We ask for a minimum of 24 hour notice for prescription refills.
- Per FDA guidelines, we are not allowed to accept any returns on medication once they have left the hospital.

I _____ have read and understand Advanced Veterinary Internal Medicine's policies.

Owner/ Authorized Agent Name (Please Print)

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