



# Brown Road Animal Clinic

1140 NORTH HIGLEY ROAD • SUITE 107 • MESA, ARIZONA 85205  
PHONE (480) 981-VETS (8387)

Date: \_\_\_\_\_

Mr. \_\_\_\_\_ Co-Owner \_\_\_\_\_  
Mrs. Owner(s) \_\_\_\_\_ Owner \_\_\_\_\_  
Dr. LAST FIRST FIRST INITIAL  
Ms.

Email \_\_\_\_\_

Address \_\_\_\_\_

CITY STATE Zip

Residence Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_ Address \_\_\_\_\_  
EMPLOYER TITLE

May we have your permission to post your pet's photo on our Facebook/Social Media Site?  YES  NO

How did you become aware of our Hospital?  
 Yellow Pages  Hospital Sign  Internet  Recommendation \_\_\_\_\_

WHO MAY WE THANK?

## Consent for exam, treatment and/or surgery

I authorize and direct the veterinarians at Brown Road Animal Clinic to diagnose, prescribe, perform therapeutic procedures, and/or surgery that their judgement may dictate to be advisable for the patient's well-being. No warranty or guarantee has been made as to the result of cure.

I hereby authorize and direct the pathologist to examine, retain for scientific purposes or dispose of all such tissues, organs, or members as shall be removed by operation or biopsy performed upon the patient.

**ALL FEES ARE REQUIRED TO BE PAID IN FULL UPON COMPLETION OF VISIT.  
A DEPOSIT IS REQUIRED IF YOUR PET IS BEING HOSPITALIZED.**

*Please indicate method of payment*

CASH  CHECK (AZ Driver's License)  MASTERCARD or VISA  
(\$31.00 Returned Check Fee)

In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all cost including in said unpaid balance, including a reasonable collection and/or attorneys' fees. A monthly "service charge" of \$10.00 will be added to all accounts that exceed 30 days.

SIGNATURE OF OWNER \_\_\_\_\_

SIGNATURE OF PERSON REPRESENTING THIS PET FOR TREATMENT IF OTHER THAN OWNER \_\_\_\_\_ RELATIONSHIP TO OWNER \_\_\_\_\_

ADDRESS OF NON-OWNER \_\_\_\_\_ PHONE \_\_\_\_\_

**PET INFORMATION** *(Please fill in the following for each pet)*

	<b>PET 1</b>	<b>PET 2</b>	<b>PET 3</b>
PET NAME			
SPECIES (CAT, DOG, OTHER)			
BREED			
COLOR			
DATE OF BIRTH			
SEX			
SPAYED OR NEUTERED			
DATES VACCINATED:			
DHLP (Distemper Combo) (Dog)			
PARVO VIRUS (Dog)			
CORONA VIRUS (Dog)			
FELINE DISTEMPER & RESPIRATORY (Cat)			
FELINE LEUKEMIA TEST (Cat)			
FELINE LEUKEMIA VACCINE (Cat)			
RABIES (Cat & Dog)			
HEARTWORM TEST			
FECAL CHECK (Worms)			
DENTISTRY			
DIET CONSISTS OF:			
MEDICATIONS PATIENT CURRENTLY ON:			
KNOWN DRUG ALLERGIES			

So that we are able to suit your individual needs - which do you feel most applies to you:

**CHECK ONE**

- I want the best medical care available for my pet; please recommend anything that you feel is necessary for good health.
- I want good medical care for my pet, but there is a limit to what I am able to have done.
- I want you to perform only the services that I request.

**CHECK ONE**

- I want to learn as much as I can about pet health care. Please explain in detail what has been done for my pet or what is needed.
- I would prefer you just summarize what has been done for my pet or what is needed.
- I want my pet healthy, but don't need to know what has been done.

How old was your pet when you acquired it? \_\_\_\_\_

How many hours is your pet outside each day? \_\_\_\_\_

What is the best time to reach you at home? \_\_\_\_\_

What prior illness or surgery should we know about your pet? \_\_\_\_\_