TRI-COUNTY ANIMAL HOSPITAL
AUTHORIZATION FOR EUTHANASIA

Owner: _____ Pet: _____

As owner, or duly authorized representative of owner, I hereby consent to and request euthanasia to be performed on the above named pet for humane reasons.

To the best of my knowledge and belief, this animal has not bitten any person during the fifteen days preceding this date.

I hereby authorize the following method of disposal:

_____ Take Home

_____ Mass Cremation

_____ Individual Cremation

_____ _____

Owner/ Representative of Owner Date

Tri-County Animal Hospital
4316 Canton Highway
Cumming, Georgia 30040
770-887-4530 – Office
www.tricountyanimalhospital.com – Web Site
info@tricountyanimalhospital.com - Email
678-807-8056 - Fax

OWNER/PATIENT REGISTRATION FORM

Thank you for giving us the opportunity to care for your pet.
Please print and complete all information listed below.

CLIENT ID:

PAYMENT EXPECTED AT TIME SERVICE IS RENDERED

INFORMATION ABOUT YOU

OWNER'S NAME: (First/Initial/Last) _____

CO-OWNER'S NAME: (First/Initial/Last) _____

ADDRESS: _____ APT. # _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: (Home) _____ (Cell)_____ (Work) _____

E-MAIL ADDRESS: _____ SOCIAL SECURITY # _____

DRIVER'S LICENSE # _____ EXPIRATION: _____ / _____ /_____ STATE: _____

EMPLOYER: _____

INFORMATION ABOUT YOUR PET

PET'S NAME: _____ DOB: _____ SPAYED/NEUTERED? YES _____ NO _____

SPECIES: _____ BREED: _____ SEX _____ COLOR(S): _____

DATE OF LAST VET CHECK-UP: _____ DATE OF LAST RABIES VACCINE: _____

PREVIOUS VET/HOSPITAL: _____

MAY WE REQUEST YOUR PET'S HEALTH RECORDS FROM HIM/HER?: _____

HOW DID YOU LEARN OF OUR CLINIC? (Yellow Pages) (Sign) (Magazine) Other:_____

IF PERSONAL RECOMMENDATION, NAME OF PERSON: _____

PAYMENT TERMS: Payment is required when services are rendered. We accept Cash, Personal Checks, Visa, MasterCard or Discover. A deposit may be required for the entire low end of our estimate on all patient admissions, and the balance is due prior to patient discharge.

PATIENT AGREEMENT: I give permission to Tri-County Animal Hospital to perform diagnostic, surgical and medical treatment as deemed necessary and/or advisable. It is further understood that such procedures of diagnosis, surgery and medical treatment will be discussed with me before proceeding except in emergency situations. In many cases, it is impossible to determine in advance the extent of surgical and/or medical treatment required and I understand that the actual cost may be lower or higher than the verbal estimate presented to me. I agree to make prompt and complete payment upon discharge of the above animal. I also understand that this does not relieve me from any financial obligation. I further understand that in case of non-payment, I will be subject to all billing toward further care and finance/collection charges associated with my account.

ACKNOWLEDGEMENT OF THE ABOVE TERMS/CONDITIONS:

_____ _____

SIGNATURE OF OWNER/CO-OWNER DATED

TRI-COUNTY ANIMAL HOSPITAL
AUTHORIZATION FOR PROFESSIONAL SERVICES

Owner: _____ Pet: _____

Contact Number(s): _____ Circle: Dog Cat Other: _____

_____ Circle: Male Female

Your pet will be undergoing anesthesia plus a surgical procedure today. Please understand that no surgical procedure is risk free. Risks may include, but are not limited to, anesthetic death and infection. In order to recognize any underlying abnormalities your pet may have, **we recommend pre-anesthetic/surgical blood work. This includes a Complete Blood Count ($37.00) to check blood cells and a Profile ($69.31) to check blood glucose, kidney and liver enzymes.** These tests help us to assess the status of your pet's health more completely and determine if there are additional precautions that need to be taken prior to anesthesia and surgery.

These tests are particularly important for aging pets 6 years and older as they provide a good baseline for comparison in the future. We **highly** recommend this blood work for geriatric pets.

I DO _____ DO NOT _____ consent to pre-anesthetic/surgical blood work described above.

I hereby authorize anesthesia/sedation and the following professional service for the above named pet:

_____ Spay / Neuter
_____ Exam
_____ Dental
_____ X-ray
_____ Abscess Surgery
_____ Cruciate Ligment Repair L / R
_____ Lumpectomy _____
_____ Microchip
_____ Wound Repair _____
_____ Other _____

The nature of this service has been described to me to my satisfaction. I understand there are risks and that no guarantee/warranty can ethically or professionally be made regarding the outcome of this service.

Tri-County Animal Hospital is a flea-free environment. To protect your pet and our other hospital/kennel residents, CapStar ($4.50) is administered to all animals visiting with us.

I understand if my pet remains unclaimed 10 days after the doctor release date, he/she will be considered abandoned and will become property of the hospital to dispose of as seen fit.

I understand I assume full financial responsibility for all services rendered, regardless of outcome. I agree to provide payment for all fees incurred upon discharge of my pet and I am liable for all legal/collection fees on unpaid balances.

_____ _____
Owner/ Representative of Owner Date