Animal Medical Center
P. O. Box 255
4012 S. Santa Fe
Chanute, Ks. 66720

NAME: _____ PHONE #:_____
ADDRESS: _____ CITY/STATE/ZIP: _____
EMPLOYER: _____ EMPLOYER PHONE #:_____
SOC. SEC. #:_____ SPOUSE SS #:_____
SPOUSE NAME: _____ SPOUSE EMPL. #:_____
SPOUSE EMPLOYER: _____ COUNTY OF RESIDENCE: _____
REFERRAL: _____ EMAIL ADDRESS_____

I certify that I own the described animal(s) and do hereby consent and authorize the ANIMAL MEDICAL CENTER and its staff to treat and/or hospitalize my pet, and to administer vaccination, medications, tests, surgical procedures, anesthesia or treatment that the doctors deem necessary for the health, safety, or well-being of the described animal(s) while it is under their care and supervision.

I authorize ANIMAL MEDICAL CENTER and its staff to disclose to any licensed veterinarian or employee of a licensed veterinarian for the purpose of treatment all information, including records, concerning the care of the described animal(s). This information includes, but is not limited to examinations, diagnosis, treatment, and prognosis. I understand that this information is confidential and protected by K.S. A 47-839 and that I am hereby waiving this privilege.

I give ANIMAL MEDICAL CENTER and its staff permission to photograph or video the described animal(s) and that such photos/video may be posted to social media accounts.

If my pet should injure itself in an escape attempt, refuse food, soil it, become ill or die while in the hospital, I will hold the ANIMAL MEDICAL CENTER and staff free of any responsibility and/or liability in the absence of gross negligence.

I further realize that I am responsible for payment for the procedures and treatments in full at the time the animal is discharged. If I neglect to pick up the animal within five (5) days of written notice that it is ready for release and mailed to the above address, you may assume that the pet is abandoned. You are then authorized to dispose of it as you see fit. Abandonment does not release me of my obligation for the bill.

_____ I AGREE TO PAY FOR TODAY'S SERVICES IN FULL UPON RELEASE-IF ARRANGEMENTS ARE NEEDED-MUST DISCUSS WITH PROPER AUTHORITY BEFORE SERVICES

I further agree that in the case of non-payment, a finance charge of 1.5% per month (18% per annum) will be charge and that any collection fees or attorney fees will be paid by me.

OWNER: _____ DATE: _____

SPOUSE: _____ DATE: _____

AMCCF

PLEASE CONTINUE ON REVERSE SIDE

Thank you for choosing our hospital to care for your pets! We look forward to serving you and your pets, and we would appreciate some background information.

CANINE		FELINE	
Pet Name_____	Pet Name_____	Pet Name_____	Pet Name_____
Breed_____	Breed_____	Breed_____	Breed_____
Sex_____	Sex _____	Sex_____	Sex_____
FE/SPAYED/M/NEUTERED		FE/SPAYED/M/NEUTERED	
Age_____	Age_____	Age_____	Age_____
Color_____	Color_____	Color_____	Color_____

Please indicate the date of the last vaccination for your pets.

_____	_____CAN. DISTEMEPER	_____	_____RABIES
_____	_____PARVO	_____	_____FEL. LEUKEMIA
_____	_____CORONA	_____	_____FEL. DISTEMPER
_____	_____PARASITE CHECK	_____	_____CHLAMYDIA
_____	_____LYME	_____	_____PARASITE CHECK
_____	_____KENNEL COUGH		
_____	_____HEARTWORM TEST		

Is your pet on any medication(s) now? _____yes _____no
If "yes," please specify: _____

Heartworm medication? _____yes _____no
If "yes" which drug? _____

Is your pet seeing any other doctor now? _____

What brings you to our clinic today?
Routine vaccinations/exam: _____
Other problem (please specify): _____
_____

Is your pet currently showing any of the following signs?

_____Vomiting	_____Unsteady gait	_____Lack of energy	_____Pain
_____Diarrhea	_____Lameness	_____Weakness	_____Sneezing
_____Coughing	_____Lack of appetite		

Does your pet have any allergies? _____yes _____no
Did you bring a fecal sample with you? _____yes _____no

____ I understand the risks of Anesthesia and do not wish to have any blood work ran at this time.

_____I would like pre-anesthetic lab work-discussed with the staff what best to run.

AMCCB