New Client Information

ACCESS
Specialty Animal Hospitals®

Thank you for choosing ACCESS Specialty Animal Hospitals.

We recognize that bringing your pet for medical diagnosis and treatment can be worrisome and stressful. So if there is anything we can do to make your time with us more comfortable, if you have any questions or need any assistance, please do not hesitate to ask any of our staff, at anytime.

Richard Mills, DVM, DACVECC
Owner – ACCESS Specialty Animal Hospitals

INTERNAL USE ONLY

Account Number:

Patient Number:

PLEASE COMPLETE BOTH PAGES...

Pet Owner's Name:

Home Address:

City: State: Zip:

Tel: (Primary) Tel: (Secondary)

Email Address:

Occupation: Employer:

Work Address:

City: State: Zip:

Name of other Authorized Agent: Tel:

Authorized Agent email Address:

Do you authorize this Agent to make urgent treatment changes if you are unreachable? *YES* ☐ *NO* ☐

Please list other Agents to whom we can release information:

Please state relationship with your Authorized Agent:

Primary Veterinarian(s): Primary Hospital / Practice:

Other veterinarians or specialty animal hospitals your pet has been treated by?

Date of Birth of Pet Owner:* *Month / Day / Year*

* *Due to the possibility of the provision and use of controlled substances and medication for your pet, we are required to obtain this information.*

PLEASE GO TO PAGE 2...

ACCESS Specialty Animal Hospitals®

Name of Pet: ______________________________

Species: Dog ☐ Cat ☐ Bird ☐ Small Mammal ☐ Reptile ☐ Other ☐ ______________________________

Breed: ______________________________ Color: ______________________________

Male ☐ Female ☐ Spayed / Neutered: *YES* ☐ *NO* ☐ *UNSURE* ______________________________

Approximate Age / DOB of your pet: ______________________________

Known drug allergies: ______________________________

Medications your pet is currently taking: ______________________________

What is the reason for your visit today? ______________________________

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Have you visited ACCESS Specialty Hospitals in the past? *YES* ☐ *NO* ☐ Location: ______________________________

How did you hear about ACCESS Specialty Animal Hospitals? ______________________________

I authorize and direct the veterinarians at ACCESS Specialty Animal Hospital to diagnose, prescribe medications (recognizing that some medications used may be off-label), perform therapeutic procedures and/or surgery that their judgment may dictate to be advisable for the well being of the patient. I also understand that no warranty or guarantee has been made as to the result or cure, and that I am financially responsible for authorized services performed.

(Please Print Name)

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(Client or Authorized Agent signature)

______________________________ *(Date)* ______________________________

Thank You.