NORTHEAST INDIANA Veterinary EMERGENCY SPECIALTY HOSPITAL

**5818 MAPLECREST ROAD**
**FT. WAYNE, IN 46835 • 260-426-1062**

**CL # _____**
***For office use only***

****PLEASE PRINT LEGIBLY ****
Have you ever received care at this office before? Yes ☐ No ☐ Date of last visit:_____

**Date**:_____ **Weight:**_____

## Owner Information

Name: _____ _____
*(Last)* *(First)*

Home Address: _____

City:_____ State:_____ Zip_____

Primary Contact Number: _____ Secondary Contact Number: _____

Owner Email: _____

Employer: _____

Spouse or Partner Name : _____ _____
*(Last)* *(First)*

Referring veterinarian:_____ Primary care veterinarian: _____

***If you do not currently have a primary care veterinarian for your pet, please state "NONE"***

## Patient Information

Patient Name: _____ Species: _____
(*Canine ,Feline ,Avian , Reptile, etc.)*

Breed: _____ Color: _____

Age: _____ Sex: MALE or FEMALE Is pet neutered or spayed? YES or NO
(circle one) (circle one)

Date of Birth: _____ Date of last vaccines: _____

Previous medical history/surgeries: _____

Reason for visit: _____

***Payment Method*: ☐ Cash ☐ Check ☐ MasterCard ☐ VISA ☐ Discover ☐ Amer Express ☐ Care Credit ☐ Scratch Pay

I hereby authorize Northeast Indiana Veterinary Emergency and Specialty Hospital, to administer needed medical and/or surgical treatment. I authorize the attending doctor and assistants to handle and treat the patient as necessary, to ensure safety for all during the evaluation. I further understand that an estimate may be provided for medical/surgical expenses but verbal consent can be obtained for treatment. I assume financial responsibility for all treatment and realize that direct payment is due at the time of service. Should payment method fail and collection efforts become necessary signer will be held responsible for costs of collection and/or attorney fee.

***Signature:** _____ **Date:** _____
~Must be at least 18yrs or older to authorize treatment.~