Angel of Mercy
ANIMAL CRITICAL CARE

For Office Use Only

Space #:_____
File #: _____
Patient #: _____

8734 Grissom Rd * San Antonio, TX, 78251 * 210-684-2105

ALL INFO MUST BE COMPLETE BEFORE EXAM

CLIENT INFORMATION

Last Name _____ First Name _____

Spouse/Significant Other Name _____

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Home # (_____)_____ Mobile # (_____)_____ Work # (_____)_____

A CURRENT DRIVER'S LICENSE OR VALID ID IS REQUIRED DL#_____

State or Country:_____ Military or veteran?_____ E-mail: _____

PATIENT INFORMATION

Pet's Name _____ Dog _____ Cat _____

CIRCLE THE ONE THAT APPLIES

Breed _____ Color_____ Age ___YRS___MO Sex _____ Neutered / Spayed / Intact

Last Vaccination Date _____ Pet's Primary Vet Clinic _____

Pet's Reason for Visit _____

_____

PLEASE READ CAREFULLY

WE DO NOT ACCEPT CHECKS AND PAYMENT IN FULL IS DUE AT TIME OF SERVICES RENDERED

EXAM FEE IS $109.00

Signature is necessary before exam and treatment

I hereby consent and authorize Angel of Mercy Animal Critical Care, Inc., its doctors, servants and representatives to administer such treatment, diagnostic surgical and anesthetic procedures as they deem necessary. None of the above will be held liable or responsible in any manner whatsoever, under any circumstances, for the care, treatment or safekeeping of the animal described above, as it is thoroughly understood I assume all risks. I hereby certify that I have read and fully understand the above authorization for medical and/or surgical treatment. I also certify that no guarantee or assurance has been made as to the results that may be obtained. Further, I assume financial responsibility for all charges incurred to patient, consent or release of medical information, and authorize direct payment to Angel of Mercy Animal Critical Care, Inc.

Owner/Agent's Signature Date