



4105 Brandywine St., N.W.
Washington, DC 20016
(202) 363-7300 OPEN 24 hours



Thank you for the opportunity to care for your pet. Please take a moment to complete this information sheet for the creation of your pet's hospital record.

Owner Information:

Owner's Name _____ Spouse/Other: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Cell/Other Ph: _____

E-mail Address: _____

Employer's Name/Address: _____

Animal Medical History:

Dog [] Cat [] DOB/Age: _____

Name: _____

Breed: _____

Male [] Female [] Altered/spayed []

Other pertinent information? _____

How did you first hear of our hospital?

[] Referring veterinarian: _____

Hospital: _____

[] Individual: _____

[] One-Book Yellow Pages [] Verizon Yellow Pages

[] AAHA referral [] Hospital sign

[] Other: _____

Driver's license no.: _____ State: _____ Exp: _____

- I request that Friendship Hospital for Animals' doctors and staff perform the services which are necessary to the examination and medical treatment of the animal(s) presented by me. I am the owner or agent for the owner of the described animal(s) and have authority to execute this consent. Provider is hereinafter understood to mean Friendship Hospital for Animals, Inc., its veterinarians, agents and employees.
I authorize the veterinarians on duty (and assistant that they may designate) to examine the animal(s) and to administer medical treatment or emergency care which is considered therapeutically and/or diagnostically necessary on the basis of the examination findings. I, therefore, hereby consent to and authorize the performance of such procedures as deemed necessary and desirable in the veterinarian's professional judgment.
I understand that the treatment of the patient(s) will be conducted with due care and in accordance with the prevailing standards of care in veterinary medicine. I certify that no guarantee or assurance has been made as to the results that may be obtained through the course of treatment undertaken by the Provider.
Accounts over 30 days past due shall pay interest at the maximum legal rate. I agree to pay all attorneys' fees, interest, collection costs and other costs of litigation incurred in the collection of past due accounts.
The Provider shall not be responsible for the loss, theft or destruction of any personal property left with my pet(s).
I understand that a written estimate for charges will be provided at my request. I also consent to the release of medical information.
I assume financial responsibility for all charges incurred to the patient for services rendered and understand that full payment is required upon request.

Signature of Owner or Responsible Agent

Date

Witness

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

Please ask a member of our Healthcare Team for a written estimate of potential costs.