FRIENDSHIP
HOSPITAL FOR ANIMALS

4105 Brandywine St. N.W.
Washington, DC 20016
(202) 363-7300 OPEN 24 hours
Primary Care |Emergency & Critical Care| Specialty Care

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:_____ Email:_____

Preferred Phone: _____ Cell/Other:_____

Do you have another veterinarian?: _____ **Veterinarian's name**:_____

Patient Information & History:

Name:_____
Dog ❑ Cat ❑ Breed:_____
DOB/Age: _____ Color:_____
Male ❑ Female ❑ Altered/spayed ❑

Other pertinent information?

_____

_____

How did you first hear of our hospital?

❑ Referring vet clinic: _____
❑ Individual: _____
❑ Friendship Website ❑ Google+
❑ Facebook ❑ Yelp
❑ Other: _____
Pet Insurance Company:_____
Policy #:_____

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, LLC., 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 understand that in the event my pet is hospitalized or left on the premises and I am unable to be reached for 24 hours, the Provider reserves the right to vaccinate and/or provide medical care as deemed appropriate by a veterinarian.
- **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.