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| GUIDRY ANIMAL HOSPITAL  503 East Gloria Switch Road Lafayette, Louisiana 70507 |  |

**Patient Intake Form**

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| **OWNER INFORMATION** | | | | | | | |
| **First Name:** | **Last Name:** | | | | **M.I.:** | **Additional Owner(s):** | |
| **Street Address:** | | | | | | | |
| **City:** | | | | | **State:** | | **ZIP:** |
| **Home Phone:** | | **Work Phone:** | | **Cell Phone:** | | | |
| **E-mail:** | | | **Employer:** | | | | |
| **How did you hear about us?**  Yellow Pages  Walk-In  Friend — Their Name  Other (Specify): | | | | | | | |
| **Referring Veterinarian:**    **Social Security Number:**  **\*\*Please Note: Social Security Number, Date of Birth, and Driver’s** | | | **Driver's License Number:**  **Date of Birth:**  **License Number are required unless you are paying with cash. \*\*** | | | | |
| **PET INFORMATION** | | | | | | | |
| **Pet’s Name:** | | | **Species:** Canine Feline Other: | | | | |
| **Breed:** | | **Sex:** Male Female  Male Neutered Female Spayed | | | | **Birthday or Age:** | |
| **Initial Presenting Problem:** | | | | | | | |
| **TREATMENT AUTHORIZATION and INFORMATION RELEASE**  I hereby authorize Guidry Animal Hospital to perform medical and initial diagnostic/surgical procedures on my pet as required for diagnosis and treatment.  I understand that I can terminate treatment at any time by contacting the doctors and assistants.  If I have been referred to this hospital by another veterinarian, I understand that they will require a summary of the care and treatment provided by Guidry Animal Hospital in order to ensure that my pet’s care can be continued without interruption. I also understand that Guidry Animal Hospital considers the identification of a referring veterinarian by me to be my authorization to release records and information to that veterinarian. | | | | | | | |
| **FINANCIAL POLICY**  Payment is due as services are rendered. For hospitalized cases, a deposit is required in advance. The balance is due upon discharge from the hospital. You may pay by cash, personal check (with proper identification), or accepted credit cards. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory.  In the event of nonpayment, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable attorney’s fees, we incur in such collection efforts.  All returned checks will incur a charge of $30.00. | | | | | | | |
| I understand that I (the owner or agent) am financially responsible to Guidry Animal Hospital for all charges relating to this patient.  I have read and agree to the treatment authorization. I have also read and accept the financial obligations. | | | | | | | |
| Signature: | | | Date: | | | | |