



24/7 ANIMAL EMERGENCY + SPECIALTY CARE

Thank you for giving us the opportunity to care for your pet. So that we may become better acquainted please provide the following:

CLIENT INFORMATION

Name:
Street Address:
City: State: Zip:
Home Phone: Email:
Cell Phone: How did you hear about us?
Have you been here before? Yes No
Primary Veterinary Hospital / Clinic and Doctor:

PET INFORMATION

Pet's Name: Species: Canine Feline Other:
Breed: Age: Color:
Sex: Female Spayed? Yes No Is your pet current on vaccinations? Yes No
Male Neutered? Yes No What do you feed your pet? (brand / type)

Payment Information

Please check method of payment for today's visit:
Cash Credit Card Debit Card Check (Checks will only be accepted upon electronic approval.)
N.J. Driver's License No. if paying by check.
Care Credit (Ask our Receptionist for information to apply.)

Authorization For Emergency Care/ Critical Care Treatment

I, (Owner's Name), the owner or agent of (Pet's Name) hereby understand, consent, and authorize the performance of emergency treatment by the staff Animerge, P.C.

PLEASE INITIAL THE FOLLOWING:

I understand the use of appropriate medications as needed for the critical care of my pet. I further understand, that during the course of the procedure(s), unforeseen conditions may arise that may necessitate the performance of additional procedures. I realized that results can not be guaranteed.

I assume financial responsibility for all charges incurred for my pet's care and I understand that all services must be paid for at the time of service.

Client / Agent Signature: Date:

Emergency Phone Number: