Corydon Animal Hospital

- Owner and Pet Information –

(Please fill in this form completely. The receptionist will be happy to assist you. Thank you.)

By signing this document, you give Corydon Animal Hospital permission to acquire your pets' previous veterinary records so we may have an updated and complete patient file.

PRIMARY OWNER INFORMATION:(**Must be 18 +.**) (RESPONSIBLE FOR MEDICAL DECISIONS AND PAYMENTS)

Last Name: _____ First Name: _____

Home Address: _____ City/State: _____

Zip Code: _____ **PRIMARY PHONE (**USED FOR ALL CLIENT COMMUNICATION): _____

OWNER Date of Birth: _____ Drivers License # _____

Secondary Phone # (EMERGENCY USE ONLY) _____ **Cell Phone #**_____

Email address:(*USED FOR PET RELATED INFORMATION*): _____

CO-OWNER INFORMATION: PLEASE INDICATE RELATIONSHIP TO PRIMARY OWNER _____

(CAN THIS PERSON MAKE MEDICAL AND/OR FINANCIAL DECISIONS) INITIAL YES_____ NO_____

Last Name: _____ First Name: _____

Phone #: _____ Drivers License #_____

New Indiana State laws require us to keep the Drivers License information for anyone who may pick up a prescription for a controlled substance on file. Without this information the CAH will not be able to fill your pet's medications or provide a written prescription.

Last Veterinarian(s) name & phone #: _____

ISYOUR PET BE LISTED UNDER ANY OTHER OWNERS NAME OR PET NAME AT YOUR PREVIOUS VET? YES _____NO_____

IF YES PLEASE LIST NAMES: _____

PET INFORMATION:

Name _____K9 OR FELINE Breed _____Color _____ Age _____ Sex F / M S / N

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Name _____ K9 OR FELINE Breed _____Color _____ Age _____ Sex F / M S / N

ALL PETS ARE TO BE CONFINED TO A KENNEL OR LEASH AND UNDER CONTROL AT ALL TIMES. IF YOU NEED ASSISTANCE WITH YOUR PET, PLEASE LET THE FRONT DESK KNOW AND THEY WILL HELP OR FIND SOMEONE TO HELP YOU.

Signature of person responsible for pet(s): _____ **Date:** _____

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To prevent the spread of infectious diseases, all hospitalized patients must be current on all vaccines and free from internal and external parasites. Your signature authorizes this level of preventive care, and the appropriate charges will be assessed on the discharge invoice.

****ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED****
There will be a service charge for any check returned unpaid
IF YOU ARE IN NEED OF FINANCIAL ASSISTANCE WE RECOMMEND: MARINER FINANCE 812.738.3281
ONEMAIN FINANCIAL 812.734.0401

THE GOAL OF THE CORYDON ANIMAL HOSPITAL IS TO PROVIDE YOUR PETS WITH THE VERY BEST MEDICAL CARE. AND TO PROVIDE THAT CARE AS PROMPTLY AS WE ARE ABLE. WE DO OUR BEST TO SEE EVERY PATIENT AS QUICKLY AS THE SCHEDULE ALLOWS.

* DUE TO AN INFLUX OF LAST-MINUTE CANCELLATIONS AND NO CALL/ NO SHOW APPOINTMENTS THE FOLLOWING STEPS WILL HAVE TO BE TAKEN*

- WE REQUIRE 24 HOURS NOTICE FOR THE CANCELLATION OF YOUR SCHEDULED APPOINTMENT. *INITIAL HERE* _____
- CLIENTS WHO MISS THEIR APPT. OR CANCEL WITHIN LESS THAN 24 HOURS MAY BE CHARGED A CANCELLATION FEE OF $35.00 *INITIAL HERE*._____
- A REPEAT OFENDER IS SOMEONE WHO HAS CANCELLED WITH OUT 24 HOURS NOTICE OR HAS NO CALL NO SHOWED FOR MORE THAN THREE TIMES. *INITIAL HERE*_____
- REPEATING OFFENDERS WILL BE SCHEDULED AS A DOUBLE APPOINTMENT AND WILL HAVE TO BE WORKED IN. IF IT STILL CONTINUES, THEY WILL BE REQUIRED TO PUT DOWN A $100.00 NON-REFUNDABLE DEPOSIT IN ORDER TO ENSURE THEIR APPOINTMENT TIME. *INITIAL HERE* _____

PLEASE READ AND INTIAL EACH SECTION.

- WITHOUT ANY ADVANCED TESTING (SUCH AS URINE TEST, CULTURES BLOOD CHEMISTRIES, X-RAYS) THE CAH CANNOT ENSURE THE CORRECT MEDICATION WILL BE PRESCRIBED. INITIAL HERE_____
- THE DOCTOR WILL PRESCRIBE THE BEST MEDICATION FOR YOUR PET'S NEEDS, BUT CAN NOT GUARANTEE YOUR PET WILL TAKE PRESCRIBED MEDICATIONS. INITIAL HERE_____
- PLEASE INTIAL ONE (OR MORE) TO INDICATE MEDICATION PREFERENCE:
  PILLS OR TABLETS_____ TRANSDERMAL_____ CHEWABLES_____ LONG ACTING INJECTABLE_____
  ORAL LIQUIDS_____EYEDROPS_____EYE OINTMENT_____NO PREFERENCE_____
- MEDICATION REFILLS WILL TAKE 24 HOURS TO PROCESS. INITIAL HERE_____
- THE CAH CAN UNDER NO CIRCUMSTANCE TAKE BACK OR REFUND ANY CONTROLLED SUBSTANCES, LIQUID MEDICATION, OR REFRIGERATED MEDICATION. INTIAL HERE_____
- IF YOU WOULD LIKE TO DONATE ANY MEDICATIONS NOT LISTED ABOVE, THEY WILL BE USED TO HELP PETS IN NEED. INTIAL HERE_____
- FOOD IS 100% SATISFACTION GUARANTEED AND CAN BE RETURNED FOR 100% MONEY BACK IF A PET WILL NOT EAT IT OR HAS PASSED AWAY. DRY FOOD MUST BE IN ORIGINAL BAG AND CANS CANNOT BE OPENED INITIAL HERE_____
- FOOD MUST BE ORDERED 10 DAYS IN ADVANCE SO IT WILL BE STOCKED IN CLINIC. YOU CAN ALSO ORDER FOOD FROM OUR ONLINE STORE AND HAVE IT SHIPPED TO YOUR HOUSE INITIAL HERE._____
- THE CAH HAS AN ONLINE STORE.
  WOULD YOU LIKE TO BE REGISTERED FOR THE CAH ONLINE STORE (YES___) (NO___)
  IF YES MAKE SURE YOU HAVE LISTED AN E-MAIL ON THE FIRST PAGE. INITIAL HERE_____

IF YOU ARE USING AN OUTSIDE PHARMACY, PLEASE LIST YOUR PREFENCES BELOW.
(IN ORDER OF PREFERENCE)

PHARMACY NAME AND LOCATION	PHARMACY PHONE NUMBER
1.	
2.	
3.	