ZIA PET HOSPITAL, LLC

373 Unser Blvd SE • Rio Rancho, NM 87124 • (505) 314-8024

Client and Pet Information

Date: Reason for visit/concerns:

Owners name (or agent):
Co-owner (if any):

Address/City/State: Zip code:

Please give us the best phone numbers to reach you (in order of importance)

Phone 1: Circle one: Home Cell Work Name:

Phone 2: Circle one: Home Cell Work Name:

Email:

Pet name: □ Dog □ Cat Breed:

Sex: □ Spayed female □ Neutered male □ Un-spayed female □ Unneutered male

Age/birthdate: Color:

Who is your regular veterinarian (and/or clinic)? □ I do not have a regular veterinarian

Is your pet aggressive with dogs, cats, or people?
Is your pet microchipped? □ Yes □No □ Unsure
How did you hear about Zia Pet Hospital?

TREATMENT AUTHORIZATION AND INFORMATION/PHOTO RELEASE

- I hereby authorize Zia Pet Hospital (ZPH) 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 technicians.
- ZPH are leaders in the veterinary medical field this case information and/or photos may be used in teaching, forms, continuing education, website, and/or literature. I authorize the release of case/patient information for such purposes; patient confidentiality (names withheld) will be maintained.
- In the event that this animal transfers ownership, I authorize release of medical information to the new owners, should they request it.
- I understand that I will receive an estimate of costs and other therapies that will need to be performed after the pet is stable and no further services will not be performed without the permission of the owner.
- Payment is due as services are rendered. For all outpatient/inpatient (hospitalized) cases, a ***deposit is required*** in advance. The balance is due upon discharge from the hospital. You may pay by cash, or accepted credit cards (we do not accept personal checks). In order to avoid any misunderstandings, please let us know if these terms are unsatisfactory.
- I understand any provided false information herein i.e. address/phone number and I cannot be reached, if I fail to pay for charges incurred for my pet's treatment, or I fail to pick up my pet without contacting ZPH to make other arrangements, my pet will be deemed to be abandoned and ZPH has full authority to do whatever it is they deem appropriate, including possible transfer of my pet to the local animal shelter.
- I understand that patient confidentiality is maintained by our staff, and therefore medical information will not be released without approval from the authorized owners or agents. Updates on patients in hospital will similarly be restricted to those listed as owners, co-owners, or authorized agents.

I (owner or agent) am financially and legally responsible to Zia Pet Hospital for all charges related to this patient. I have read and agree to the treatment authorization. I have also read and accept the financial obligations, and understand that payment is due at the time of service.

Signature: _____ **Printed Name:** _____ **Date**: _____

Witness Signature: _____ **Printed Name:** _____ **Date**: _____

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Treatment Authorization and Information/Photo Release

Pet's Name: **Owner's First and Last Name:**

- _____ (**Initial**) I am the undersigned owner of pet listed above agent of my pet or the Good Samaritan responsible for seeking veterinary care for the patient.
- _____ (**Initial**) I consent to the examination of this pet by staff veterinarians at Zia Pet Hospital (ZPH). I also agree that after approval, the veterinarian(s) may prescribe medication to, treat, hospitalize, sedate, anesthetize, and/or perform surgery on this pet. I understand that I can terminate treatment at any time by contacting the doctors and technicians.
- _____ (**Initial**) I understand that some risks always exist with treatment, anesthesia and/or surgery and that I am encouraged to discuss any concerns I have about those risks with the attending veterinarian before the procedure is initiated. I understand that there is no stated or implied guarantee of success of treatment and that owner compliance and response to therapy will determine if further treatment is necessary and associated costs. Should unexpected life-saving emergency care be required and the attending veterinarian is unable to reach me, the hospital staff has my permission to provide such treatment, and I agree to pay for such care.
- _____ (**Initial**) I understand payment is due as services are rendered. I understand and estimate of veterinary services requested will be provided and require written approval. For all outpatient/inpatient (hospitalized) cases, a ***deposit is required*** in advance. The balance is due upon discharge from the hospital. You may pay by cash, or accepted credit cards (**we do not accept personal checks**). In order to avoid any misunderstandings, please let us know if these terms are unsatisfactory.
- _____ (**Initial**) If my pet is hospitalized, I agree ***to pay a deposit of 50%*** of the estimated fees. I agree to assume financial responsibility for the remaining fees and will provide payment via **cash or credit card** (we do not accept personal checks) at the time my pet is discharged from the hospital. In the event my pet is hospitalized for more than forty-eight hours and the attending doctor is unable to reach me, I understand it is my responsibility to call the hospital at least every forty-eight hours to inquire as to the medical status of my pet and the fees incurred for medical services up to that day.
- _____ (**Initial**) I understand that veterinary care during nighttime hours and/or weekends is provided at the discretion of the attending veterinarian. Continuous presence of personnel may not be provided during these hours.

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Pet's Name: **Owner's First and Last Name:**

Treatment Authorization and Information/Photo Release Cont.

- _____ (**Initial**) I understand that if I provide any false information herein such as address or phone number so that I cannot be reached, if I fail to pay for charges incurred for my pet's treatment, or I fail to pick up my pet and have not contacted Zia Pet Hospital (ZPH) to make other arrangements, my pet will be deemed to be abandoned and ZPH has full authority to do whatever it is they deem appropriate, including but not limited to transferring my pet to the local animal shelter.
- _____ (**Initial**) I understand patient confidentiality is maintained by ZPH and therefore medical information will not be released without approval from the authorized owners or agents. Updates on patients in hospital will similarly be restricted to those listed as owners, co-owners, or authorized agents. (Initial): _____
- _____ (**Initial**) (**Please circle**): I **DO** or **DO NOT** allow my pet's case information and/or photos may be used in teaching, forms, continuing education, website, social media and/or literature. I authorize the release of case/patient information for such purposes; patient confidentiality (names withheld) will be maintained.
- _____ (**Initial**) In the event that this animal transfers ownership, I authorize release of medical information to the new owners, should they request it.
- **____ (Initial)** I understand that this ***Treatment Authorization and Information/Photo release form <u>will</u> <u>remain in effect indefinitely</u>*** for the duration of my pet's veterinary past, present and future care at Zia Pet Hospital. At any time, I can notify ZPH and update the form (owner must be present at ZPH).

I (owner or agent) am financially and legally responsible to Zia Pet Hospital for all charges related to this patient. I have read and agree to the treatment authorization. I have also read and accept the financial obligations, and understand that payment is due at the time of service.

Signature: _____Printed Name: _____Date: _____

Witness Signature: _____Printed Name: _____Date: _____

<u>Please verify that you can be reached today/tomorrow at the number(s) below.</u>

Primary Phone (Cell): **Work Phone:**

We are proud to be locally owned and operated veterinary practice that cares about you, our community, and the well-being of all pets. The dollars you spend to care for your pet are kept right here in New Mexico. Thank you for trusting us with your pet's care.

ZIA PET HOSPITAL, LLC

Travel SOAP

Reason for Visit: _____

Duration of problem: _____

Is your pet up today date on vaccines? □Yes □No

What vaccines are needed today? □Rabies □DA2PP □Bordatella □FVRCP □FeLV

Has your pet ever experienced a vaccine reaction? □Yes □No

If yes please explain: _____

How long have you had this pet for? _____

Where did you get your pet from? □Breeder □Rescue □Other: _____

What is your pet's environment? □Indoor □Outdoor □Indoor/Outdoor

Other pets in home? □Dogs: _____ □Cats: _____ □Other: _____

Are any of the other pets in the home have similar medical symptoms? □Yes □No

Does your pet have any previous medical history we should be aware of? □Yes □No

If yes, please explain: _____

Has your pet had any previous surgical procedures? □Yes □No

If yes, please explain: _____

Does your pet have any allergies you are aware of? □Yes □No

If yes, please explain: _____

What is your pets current diet/food brand? □Dry: _____ □Wet: _____

Amount: _____ Frequency: _____

Is your pet on medications or supplements currently? (Note this includes any over the counter medications)

□Yes □No

If yes, please fill in the table below

Medication Name	Dosage	Directions

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Travel SOAP

Current Symptoms
□ Vomiting How Frequently? _____ Abdominal Effort? □ After meals? □ After water intake? □ History of foreign object ingestion? □ Any new treats/human foods? □
□ Diarrhea How Frequently? _____ Score: _____ Blood Seen? Frank □ Dark□ Mucus Seen? □ Urgency? □ Any new treats/human foods? □
□Sneezing Productive? □ Color of Mucus: _____ Frequency: _____
□Coughing Productive? □ Color of Phlegm: _____ Frequency: _____
□ Itching Itch Score: _____ Area Effected: _____
□Limping Grade: _____ Leg Effected: _____
□ Pain Area Effected: _____ Known Trauma? _____
□ Lethargy □ Lesions □ Ear Odor/Discharge □ Eye Odor/Discharge □ Hematuria
Increased □Urination □Drinking □Eating □Weight Gain □Other:
Decreased □Urination □Drinking □Eating □Weight Loss □Other:
Other:_____ _____ _____ _____