Client ID_____

South Atlanta Veterinary Emergency & Specialty

1090 Highway 54 East ● Fayetteville, Georgia 30214 ● (770) 460-8166

Date:_____

PLEASE PRINT

OWNER/RESPONSIBLE AGENT_____

_____

STREET ADDRESS_____

CITY_____ STATE_____

ZIP CODE_____

PRIMARY PHONE_____

SECONDARY PHONE_____

E-MAIL_____

REGULAR VETERINARIAN / CLINIC_____

I give SAVES permission to record photos, video or audio of my pet for educational or marketing purposes. _____ (Owners Initials)

PETS NAME_____

SPECIES_____ BREED_____

COLOR_____ SEX_____ AGE_____

REASON FOR VISIT_____

_____

SPAYED/NEUTERED YES ☐ NO ☐
VACCINES UP TO DATE YES ☐ NO ☐
HEARTWORM PREVENTION YES ☐ NO ☐

CURRENT MEDICATIONS_____

_____

ALLERGIC TO MEDICATIONS_____

☐ **EMERGENCY** ☐ **OPHTHALMOLOGY** ☐ **SURGERY** ☐ **EXOTICS** ☐ **CARDIOLOGY**

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT

Time In _____ MUST BE 18 YEARS OF AGE OR OLDER TO SIGN Time out _____

I hereby authorize South Atlanta Veterinary Emergency & Specialty, its representative, agent, and employees to administer medical treatment, medications, anesthetics and surgery as is considered therapeutically, diagnostically, or humanely necessary or appropriate on the basis of the findings during the course of evaluation of the above described animal. I understand that a SAVES agent will present an estimate for the above stated services if I am inside the SAVES premises. If my animal has been considered abandoned by SAVES, I relinquish all rights relating to the treatment of the animal above. I consent for the release of medical information pertaining to the above animal from my veterinarian and/or specialist. I understand that after seeking emergency services at SAVES, I am instructed to follow up with my regular veterinarian immediately.

I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AUTHORIZATION AND THE REASONS FOR SUCH TREATMENT, MEDICATIONS, OR SURGERY, ITS ADVANTAGES AND POSSIBLE COMPLICATIONS (IF ANY), AS WELL AS POSSIBLE ALTERNATIVE MEANS OF TREATMENT.I ASSUME ALL FINANCAIL RESPONSIBILITY FOR ALL CHARGES INCURRED TO THE PATIENT AND AUTHORIZE DIRECT PAYMENT TO SOUTH ATLANTA VETERINARY EMERGENCY & SPECIALTY.

PAYMENT REQUIRED WHEN SERVICES ARE RENDERED **A DEPOSIT IS REQUIRED ON ALL HOSPITALIZED PATIENTS**

EMERGENCY DEPARTMENT EXAM FEE IS $135.00

Owner/Agent Signature_____ **Date**_____

OFFICE USE ONLY: **CCC INITIALS**_____ **TECH INITIALS**_____ **DR INITIALS**_____

WEIGHT_____TEMP_____ RR_____ RE_____ PULSE_____ PULSE QUALITY_____ MM_____ CRT_____

HISTORY/SYMPTOMS: _____

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