

Quail Ridge Animal Hospital
937 Mica Dr. Suite 18 Carson City, NV 89705
Ph: (775) 267-488 / Fax: (775)267-3337

Internal Use ONLY		
Yes	No	CPR
Yes	No	DNR

Pet Daily Admission Information

Client Name: _____ Pet Name: _____

Phone Number: _____

Species: _____ Breed: _____ Male Female

Has your pet been seen by us previously? Yes _____ No _____ (If not, please fill out a new client form)

When was your pet's last meal, what was eaten and amount? _____

Is your pet sensitive or allergic to any medications or food, if so, please list: _____

What medication, if any, has your pet been given in the past 24 hours?

Name of Medication	Amount Given	Time

What Vaccinations, if needed, would you like us to give to your pet today?

Canine

- Rabies - \$29
- DA2PP - \$29
- Lepto - \$29
- Bordetella - \$29
- Rattlesnake - \$31

Feline

- Rabies - \$29
- FELV - \$42
- FVRCP - \$29

Please describe the problem(s) your pet is having, pertinent history leading up to the current condition and any previous major medical concerns or recent events that could contribute to the illness.

Has your pet bitten anyone in the past 14 days? Yes No

If yes, please explain: _____

After the initial exam by the doctor, would you like us to:

- Treat your pet and proceed with medical care (incurring all costs affiliated with this care) _____ (Initial)
- Call you at the above listed phone number to discuss findings and to go over the treatment plan including an approximate financial estimate. This will be done **BEFORE** medical treatment. _____ (Initial)

I understand that if overnight care is needed for my pet, QRAH **DOES NOT** have staff on site between the hours of 6:00pm-7:30am and my pet will be left unattended. An alternative emergency hospital for overnight care will be offered. _____ (Initial)

While I accept that all procedures will be performed to the best of the abilities of the staff at this hospital, I understand that no guarantee or warranty has been made regarding the results that may be achieved. I agree to pay a deposit of the estimated fees, assume financial responsibility for the remaining fees, and provide payment via cash, credit card, or check at time my pet is discharged from the hospital. **Should unexpected life-saving emergency care be required the staff ____ has / ____ has not my permission to provide such treatment and I agree to pay for such services. Professional fees are to be paid at the time services are performed.**

In admitting my pet(s) for diagnostics, treatment, or surgery, I authorize the Veterinarians at QRAH and staff to administer treatment and/ or perform diagnostic or surgical procedures as deemed necessary.

Signature: _____ Date: _____