**Central Carroll Animal Emergency**

**1030 Baltimore Blvd Suite 180**

**Westminster, Maryland 21157**

**(P) 410-871-2000 / (F) 410-871-9001**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient ID: \_\_\_\_\_\_\_\_\_\_

Time/Initial: \_\_\_\_\_\_\_\_ Exam Room: \_\_\_\_\_\_\_\_

**Client Information:**

***Please legibly print all of the following information*** Have you been here before? YES NO

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #

**(Required if writing a check)**

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Primary Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Veterinarian/Clinic’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR MEDICAL AND/ OR SURGICAL TREATMENT AND FINANCIAL RESPONSIBILITY**

I HEREBY AUTHORIZE Central Carroll Animal Emergency, LLC to examine and treat the animal described below medically and/ or surgically. I understand there is no guarantee of successful treatment. I also consent to the administration of such anesthetics as are necessary

and surgical procedures of an emergency nature. I assume complete financial responsibility for any and all charges incurred to patient for such exam and treatment. I further understand that emergency patients **must** be picked up from this facility by **8:00 am. Through the week we do not offer 24 HR care**. Patients admitted Friday, Saturday, Sunday or Monday nights may, if necessary, remain at Central Carroll Animal

Emergency until Tuesday at 8:00 am and I will be responsible for related charges, including hospitalization. I hereby agree to pay at the time services are rendered. **I understand that Central Carroll Animal Emergency, LLC does not bill for any services or items**. I have read and fully understand this authorization for medical and/ or surgical treatment.

**I UNDERSTAND THERE IS A $95 EXAM FEE*.***

**We accept the following (with valid Drivers License):** Cash Visa MasterCard Discover American Express Checks

**\*There will be a $35 return check fee for all returned checks\***

We **CANNOT** accept Home Equity Line of Credit Checks or Business Checks.

**If money is an issue please ask us about CARE CREDIT or SCRATCHPAY**

Responsible Agent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information: *Please print all information***

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Species: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Breed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: MALE FEMALE Spayed or Neutered: YES NO AGE: \_\_\_\_\_\_\_\_\_ Color: \_\_\_\_\_\_\_\_\_\_

Up to Date on Vaccines: YES NO Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Brief description of symptoms/complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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*Every animal’s health is very important to us; however, please understand that we are an emergency hospital. The most seriously injured and critical patients must be seen immediately. This can result in an extended wait. We appreciate your patience in such times. Thank you.*