ALL PETS MEDICAL AND SURGICAL CENTER
3070 Temple Ave
Phillips Ranch, CA 91766
909.622.1044

CONTACT INFORMATION

Dr./Mr./Mrs./Ms./Miss _____ Cell #: _____
Last First

Street Address: _____ Home #: _____
(No PO Box # Please)

City: _____ Zip: _____

Occupation: _____DOB___/___/____ Work #: _____

Spouse: _____ Cell #: _____
Last First

Occupation: _____DOB___/___/____ Work #: _____

E-mail:_____

OK to receive Text Appointment Reminders?
Plz initial: YES: _____No: _____

How did you hear about us? (Please circle one)

Emergency Clinic, Other DVM	Drive By, Saw Sign	Yellow Pages	Referred by: Name: _____	Internet	Pet Shop, Kennel, Groomer	Previous Client	Other: _____

Preferred method of payment:

Cash	Check	Debit/Credit Card
☐	**3rd Party Checks are not accepted. All check writers must be listed on this account and provide their CDL #**	☐

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.
FOR CHECK PAYMENTS OVER A CERTAIN AMOUNT, BANK VERIFICATON WILL BE PERFORMED.
THIRD PARTY CREDIT IS AVAILABLE FOR QUALIFIED APPLICANTS.
CHECKS ARE NOT ACCEPTED FOR NEW CLIENTS.

AUTHORIZATION TO TREAT

I, the undersigned, owner or authorized agent for the pet(s) presented for care, hereby authorize the staff of the All Pets Medical & Surgical Center to examine, test and administer such treatment as is determined necessary on the basis of findings during the course of evaluation. I understand that during the performance of procedures or operations unforeseen conditions may be revealed that necessitate the extension of medical or surgical care. Therefore I hereby consent and authorize the performance of such procedures or operations as are necessary as determined by the veterinarian's best professional judgment. I also authorize the use of appropriate immunizations, antiparasitics, anesthetics and medications and am aware that they do carry risks to health and life. I agree to the hospital's use of medications commonly used in veterinary medicine today, whether label or off-label. Due to the impossibility of disinfecting for Salmonella, APMSC will not hospitalize patients suspected of Salmonella infections. I grant APMSC the right to take photographs of me and/or my pet, and to copyright, use & publish the same in print and/or electronically with or without my name and for any lawful purpose, such as publicity, illustration, advertising, and Web content. I am aware that veterinary service during nighttime hours, some daytime hours, and/or, weekends, is provided at the discretion of the veterinarian in charge. Continuous presence of personnel may not be provided during these hours. I am aware that after-hours care is available at East Valley Emergency Pet Clinic and Dr. Beighlie is a stockholder in EVEPC. I understand that I am not obligated to use EVEPC that APMSC's doctors recommend and I may choose any business that offers the needed services. I understand that no warranty or guarantee of successful treatment is expressed or implied. I further stipulate that I will pay such fees that are accrued in said procedures at the time that pet is released. I am aware that if I do not retrieve my pet at discharge that it will be deemed abandoned and that I will be responsible for all charges until such time that the staff disposes of the pet according to CA Civil Code Section 1834.5 it is also agreed that if I do not pay this account as agreed that the past due accounts are subject to the cost of collection ($55), interest (19% per annum) and attorney's fees. I agree to pay the current service fee on all returned checks. Appointments not canceled 24 hours prior are subject to a cancellation fee. I further certify that I am at least 18 years of age. Accepted today by:

X_____DriversLicense#_____Exp Date:_____ Witness: _____ Date: ___/___/___
Owner #1/Agent

X_____ DriversLicense#_____Exp Date:_____Witness: _____ Date: ___/___/___
Owner #2/Agent