Pet Palace Veterinary Clinic

Philip N. Haas, D.V.M.
Karen Harrison, D.V.M.
4098 S. Parker Road
Aurora, Colorado 80014
(303) 699-0477

CLIENT INFORMATION

PLEASE PRINT

OWNER'S NAME: ______________________________ Spouse's Name: ______________________
(last) (first) (initial) (first) (initial)

OWNER'S ADDRESS: ____
(apartment or unit number)

OWNER'S ADDRESS CONT: ____
(city) (state) (zip code)

PHONE NUMBERS: Home: ____________ Owner's Cell#: ______________ Spouse's Cell#: __________

OWNER'S OCCUPATION: ______________________________ Business Phone: ______________

SPOUSE'S OCCUPATION: ______________________________ Business Phone: ______________

Driver's License Number: ________________________ Social Security Number: ______________

E-mail Address: ____

ANIMAL INFORMATION

NAME	DOG	CAT	OTHER	BREED	SEX	SPAYED OR NEUTERED	BIRTH DATE MM/DD/YY	COLOR
						YES NO		
						YES NO		
						YES NO		
						YES NO		
						YES NO		

AUTHORIZATION FOR TREATMENT

I authorize **PET PALACE VETERINARY CLINIC** to treat the animal(s) described above and any new animals as they join the family. This may include the use of any medication, anesthesia, surgery, and/or restraint necessary. I understand that I am not guaranteed a successful outcome, nor will I hold the clinic or its personnel responsible for my animal's recovery. I further accept all financial responsibility for services rendered on behalf of the patient(s) and understand that payment is due upon release of my animal from the hospital; unless prior arrangements have been agreed to with Dr. Philip Haas.

*You will be charged a $25.00 cancellation / re-schedule fee if surgical appointment is canceled within 24 business hours of the scheduled time.

Owner's Signature: ____ Date: ______________

Signature of authorized agent if other than owner: ____________________________ Date: ______________

Relationship to owner: ____

If you were referred to us, whom may we thank: ________________________________

Admitting Clerk: ____

10.2014