Our mission is to practice the highest quality of veterinary medicine, showing empathy and compassion for patients and clients while excelling in customer service and client education.

-Terri Parrott, DVM & Jamie Nenezian, DVM - Co Owners

Client - Patient Registration

Owner Information

Name: ______________________________ Cell Phone: __________________________
Address: ____________________________ Alternate Phone: ______________________
City/State/Zip: _______________________ Email: ______________________________

I authorize the following individual to make medical decisions about my pet and have access to records.

Name: ____________________________
Cell Phone: _________________________

We gladly accept the following types of payments:

Visa - MasterCard – Discover - AMEX - Cash - Care Credit - Scratch Pay

(NO CHECKS WILL BE ACCEPTED)

Patient Information

Patient Name: ________________________ Age: ________ **DOB:** ___________
Breed: ___________ Color: __________ Sex: __________

Cardiopulmonary Resuscitation Directive (CPR)

In the event of an emergency, while here for an appointment that requires CPR, I authorize the following CPR Directive for my pet.

_______ **Yes**, I Authorize that CPR be performed which may include but is not limited to endotracheal intubation, manual ventilation, administration of emergency drugs, and/or chest compressions. Additional costs are associated with CPR and that I acknowledge that I will be responsible for all costs that will incur.

________**No**, I decline CPR and that no attempt to resuscitate my pet be made.

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*Veterinary Hospital you would like us to share medical records with: __________________

Record Release:

______ **Yes,** I authorize you to release my pet's medical records to any professional establishment such as other veterinary hospitals, clinics, pet adoptions groups, and pet insurance companies with no expiration date to release this information.

Please make my pet a star! ______ **Yes, I** authorize photographs/video of my pets by the staff of St. Charles Veterinary Hospital (SCVH) for the purpose of posting on Facebook, the SCVH website, and other uses for professional education and promotion.

No thank you, my pet is shy ______

Terms and Conditions: I understand that I am entering into a partnership with St. Charles Veterinary Hospital and its team with the goal to provide excellent veterinary care for my pet. As the rightful owner/agent of the above pet, I hereby authorize the veterinary medical team of St. Charles Veterinary Hospital to examine, prescribe for, and treat my pet. I assume all responsibility for the charges incurred associated with these services. A treatment plan and financial estimate for recommended services will be provided for all hospitalized and surgical pets and upon request at any time. I understand that all charges are to be paid when services are rendered and/or prior to hospitalization or surgical procedures. **As required by law I acknowledge that in order to maintain a valid veterinary client relationship my pet will be required to have an exam performed by one of our veterinarians every 12 months as well as any needed vaccines that are required by law.**

______ I agree to honest communications with St. Charles Veterinary Hospital team while communicating in a positive respectful manner and that I am also 18 years of age or older.

We strive to provide the highest quality of veterinary medicine to every patient as well as communicate to our clients in a compassionate and empathetic manner. However, things do happen, and if your experience is ever less than wonderful, please ask to speak with one of our managers who can help alleviate the concern and make future experiences better.

We value you and your family and are excited that you are joining our family here at St. Charles Veterinary Hospital. Welcome to our family!

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Client Signature Date

*****Please only complete the below portion of this form if you are requested to do so by a team member. *****

EMERGENCY STABALIZATION TREATMENT

If your pet is triaged and found to be in critical condition, immediate treatment and medications will need to be taken. Please **initial** below your choice regarding starting immediate stabilization treatment.

_______ **Yes**, I Authorize the start of emergency stabilization treatment and understand that a payment of **$500** will be taken immediately and that additional costs will/may occur. _____**Yes, I authorize CPR** _____**No, I decline CPR**

________**No**, I decline the immediate start of emergency medical stabilization and/or CPR.

Owner/Agent:___________________________________ SCVH Witness:_______________________________________