CLEAR FORM PRINT

ANIMAL EMERGENCY MEDICAL CENTER

3511 Pacific Coast Highway, Suite A
Torrance, CA 90505
310-325-3000 Fax: 310-257-0900
www.aercvet.com

OPEN 24 HOURS

DATE : _____

TIME : _____

Last Name	First	Spouse	Home Phone
Address Unit #	City,State,Zip		Cell Phone
Employer	Client Date Of Birth	E-mail	Work Phone

Pet's Name	Species	Breed
Sex ☐ Male ☐ Female / Neutered / Spayed ☐ Yes ☐ No	Patient Age / Entering Complaint	Color
Your Family Veterinarian / Under Treatment ☐ Yes ☐ No / Treatment / RDVM Radiographs ☐ Yes ☐ No		Admitting Veterinarian
Your Family Veterinarian's Hospital	Your Family Veterinarian Hospital's Phone Number	Does Your Pet Have Insurance? Yes ☐ No ☐

Where did you hear about us?
☐ My Vet ☐ Friend/Family ☐ Yellow Pages ☐ Been here before ☐ Yelp ☐ Website/Internet ☐ Newspaper ☐ Pet Store ☐ Saw Sign ☐ Other

AUTHORIZATION FOR EXAMINATION

I hereby authorize my pet to be examined by the Doctor on Duty at Animal Emergency Referral Center. **I understand that I will be charged an $95.00 emergency exam fee.**

X _____
SIGNATURE OF OWNER OR RESPONSIBLE AGENT WITNESS

AUTHORIZATION FOR MEDICAL AND SURGICAL TREATMENT

I, the undersigned, owner of the admitted patient, hereby authorize the Doctor on Duty at Animal Emergency Referral Center (and whomever s/he may designate as his/her assistant (s) to administer such treatment as is necessary, and to perform surgical procedures and such additional medical procedures as are considered therapeutically and/or diagnostically necessary on the basis of findings during the course of said evaluation. I also consent to the administration of such anesthetics as are necessary.

I hereby certify that I have read and fully understand the above Authorization for Medical and/or Surgical Treatment, the reasons why the above named surgery is considered necessary, it's advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by the Doctor on Duty at Animal Emergency Referral Center at time services are rendered. I also certify that no guarantee or assurance has been made as to the results that may be obtained at time services are rendered. Further, I assume financial responsibility for all charges incurred to patient, consent to release of Medical Information, and Authorize full direct payment to the Animal Emergency Referral Center at time services are rendered.

X _____
SIGNATURE OF OWNER OR RESPONSIBLE AGENT WITNESS

AUTHORIZATION FOR EMERGENCY TREATMENT

I hereby authorize, consent and direct the Animal Emergency Referral Center to perform heroic and lifesaving procedures on my pet. I understand the Doctor on Duty will speak with me as soon as possible; to inform me of my pet's condition, but immediate treatment is necessary.

I understand that the estimate for these emergency procedures is $400.00-$700.00. Once stable, additional treatment may be necessary; the doctor will provide a written estimate prior to performing any additional procedures. By my signature, I consent to this emergency estimate and agree to pay the charges in full at the time services are rendered.

X _____
SIGNATURE OF OWNER OR RESPONSIBLE AGENT WITNESS

Pharmacy Notification

I acknowledge that I have the right to elect the pharmacy of my choice if a prescription needs to be filled for my pet.

X _____
SIGNATURE OF OWNER OR RESPONSIBLE AGENT WITNESS

Release Patient to:
X _____ DATE _____ TIME _____
SIGNATURE OF OWNER OR RESPONSIBLE AGENT

ADM. DVM Check In Technician/Reception DISCH. DVM Check Out Technician/Reception

Intravet : _____