PAW HEALTH NETWORK, INC.
PATIENT CHECK-IN FORM

Have you/your spouse been here before? ☒ Yes ☐ No **Has this patient been here before?** ☒ Yes ☐ No

CAREGIVER INFORMATION

You are the… ☒ Owning Caregiver ☐ Acting Agent

Last Name Owning Caregiver Last Name
First Name Owning Caregiver First Name
Spouse Owning Caregiver Spouse Full Name*
Address Owning Caregiver Street Address
City OC City **State** OC State
Primary Care Veterinarian Owning Caregiver Primary Veterinary Clinic

Primary Phone Owning Caregiver Primary Phone
Secondary Phone Owning Caregiver Secondary Phone*
Work Phone Owning Caregiver Work Phone*
Email Owning Caregiver Email Address
County OC County Zip OC Zip Code

PATIENT INFORMATION

Species ☒ Canine ☐ Feline ☐
Gender ☐ Male ☒ Female
Status ☒ Intact ☐ Spayed/Neutered

Name Patient Name
Breed Patient Breed
Coat Color Patient Coat Color(s)
Age/Birth Date Patient Age or Birthdate

MEDICAL INFORMATION

Short Description of Presenting Problem Patient Symptoms / Presenting Complaint
Major Surgeries / Medical Diagnoses Patient Major Medical History*
List Flea/Tick/Heartworm Prevention Patient's Current Preventative Medications*
Food Brand & Type Patient's Diet Information
Known Medication Allergies Patient Medication Allergies*
Current Medications Patient Current Medications (Name, Dosage, Time of Last Dose)*`
Last Vet Visit & Vaccination(s) Patient's Most Recent Vet Visit & Vaccination History

PAYMENT INFORMATION | TERMS & CONDITIONS

☐ Cash ☐ Credit/Debit Card
☐ Check ☐ CareCredit Card

By si[illegible] accept full financial responsibilit[illegible] related to pa[illegible] complete physical examin[illegible]d/or partial or complete cons[illegible] with a veterinarian[illegible] veterinary staff.

I acknowled[illegible] no guarantees [illegible]ade regarding services ren[illegible] treatments performed, or p[illegible] dispensed b[illegible] Health Network, Inc.

Regardless of outc[illegible]e or death, I accept full financial respon[illegible] for services rendered, trea[illegible]rmed, or products dispensed while the listed ani[illegible] was under the care of PA[illegible] Network, Inc.

Should I decline di[illegible](s) [illegible] treatment(s), I release PAW Health Networ[illegible] all employees, all o[illegible]nd all a[illegible] of liability or loss by having gone aga[illegible]dical advice.

I understa[illegible] if timely payments are n[illegible]e, any outstanding balan[illegible] will be sent to the Ma[illegible] County Court of Small Cla[illegible] understand I will [illegible]onsible for all appli[illegible]ourt costs and fees, including actu[illegible]ays' fees.

*I understand[illegible] written and[illegible]al estimates are produced in good[illegible]nd may be a[illegible] **within a range o[illegible]e listed value**.*

*I ack[illegible]ge that PAW Health Networ[illegible] will be faxing/emailing[illegible]cal record to[illegible]nary care veterinarian. I, at an[illegible] may request a[illegible]al record by [illegible] **a Medical Record Request Form**.*

consent that at any time PAW Health Network[illegible]uest and receive full medical records from any veterinary clinic at any ti[illegible] acknowledge that any officer of the state may receive my medical record wi[illegible]nt or prior knowledge.

to make an initial deposit prior to service[illegible]ed tr[illegible]s performed, or p[illegible] dispensed. I also agree to remedy a[illegible]ining charg[illegible]n completion or fulfil[illegible]

SIGNATURE **DATE**

ARRIVAL TIME: Arrival Time **ACCOUNT NUMBER:** IMPROMED ACCOUNT NUMBER **EMPLOYEE:** Employee Initials

PAW HEALTH NETWORK, INC.
PATIENT CHECK-IN FORM

Have you/your spouse been here before? ☒ Yes ☐ No **Has this patient been here before?** ☒ Yes ☐ No

CAREGIVER INFORMATION

You are the… ☐ Owning Caregiver ☒ Acting Agent

Last Name Acting Agent Last Name
First Name Acting Agent First Name
Spouse Acting Agent Spouse Full Name*
Address Acting AgentStreet Address
City AA City **State** AA State **County** AA County Zip AA Zip Code
Primary Care Veterinarian —

Primary Phone Acting Agent Primary Phone
Secondary Phone Acting Agent Secondary Phone*
Work Phone Acting Agent Work Phone*
Email Acting Agent Email Address

OWNING CAREGIVER PATIENT MASTER LABEL

ecies Canine Feline
Gender ☐ le ☐ Female
Status ☐ Int ☐ Spayed/Neutere
oat Color
h Date

Short De tion of Pres g Problem
Major S ies / l cal Diagnoses
List Flea/Th tworm Prevention
od Brand & Type
wn Me tion Allergies
Curre dications
Last Vet Visit & Vac tion(s)

PAYMENT INFORMATION | TERMS & CONDITIONS

☐ Cash ☒ Credit/Debit Card
☐ Check ☐ CareCredit Card

By signing, I accept full financial responsibility of fees related to partial or complete physical examination and/or partial or complete consultation with a veterinarian and/or veterinary staff.

I acknowledge that no guarantees are made regarding services rendered, treatments performed, or products dispensed by PAW Health Network, Inc.

Regardless of outcome, including life or death, I accept full financial responsibility for services rendered, treatments performed, or products dispensed while the listed animal is or was under the care of PAW Health Network, Inc.

Should I decline diagnostic(s) and/or treatment(s), I release PAW Health Network, Inc., all employees, all owners and all affiliates of liability or loss by having gone against medical advice.

I understand that if timely payments are not made, any outstanding balance(s) will be sent to the Marathon County Court of Small Claims. I understand I will be responsible for all applicable court costs and fees, including actual attorneys' fees.

*I understand that all written and/or verbal estimates are produced in good faith and may be **accurate within a range of 15% the listed value**.*

*I acknowledge that PAW Health Network, Inc. will be faxing/emailing a medical record to my primary care veterinarian. I, at any time, may request a medical record by fulfilling a **Medical Record Request Form**.*

I consent that at any time PAW Health Network, Inc. may request and receive full medical records from any veterinary clinic at any time. I also acknowledge that any officer of the state may receive my medical record without consent or prior knowledge.

I agree to make an initial deposit prior to services rendered treatments performed, or products dispensed. I also agree to remedy any remaining charges upon completion or fulfillment.

SIGNATURE ACTING AGENT SIGNATURE **DATE** DATE AT TIME OF CHECK-IN

ARRIVAL TIME: Arrival Time **ACCOUNT NUMBER:** IMPROMED ACCOUNT NUMBER **EMPLOYEE:** Employee Initials