PAW HEALTH NETWORK, INC.

PATIENT CHECK-IN FORM

Have you/your spouse been here before? [X] Yes [ ] No

Has this patient been here before? [X] Yes [ ] No

CAREGIVER INFORMATION

You are the... [X] 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 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

Primary Care Veterinarian Owning Caregiver Primary Veterinary Clinic

PATIENT INFORMATION

Species [X] Canine [ ] Feline [ ] ______

Gender [ ] Male [X] Female

Status [X] 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 [X] 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 OWNING CAREGIVER SIGNATURE **DATE** DATE AT TIME OF CHECK-IN

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

PAW HEALTH NETWORK, INC.

AUTHORIZATION RELEASE

I am ☐ the **owning caregiver** or ☐ the **acting agent** on behalf of the owning caregiver for the listed animal. I have the authority to make medical and financial decisions regarding its health and well being.

I/We are electing…

☐ Lab Work ☐ Hospitalization ☐ Sedation ☐ Pain Meds
☐ X-rays ☐ Catheterization ☐ General Anesthesia ☐ Medication
☐ Ultrasound ☐ Fluid Therapy ☐ Local Anesthesia

☐ Procedure ______________________________

☐ Other ______________________________

I acknowledge that the attending veterinarian and/or support staff has appropriately informed me of all diagnostic and therapeutic options that pertain to the listed animal's presenting complaint and clinical abnormalities.

I consent to the administration of medications that are determined necessary by the attending veterinarian(s) to reduce pain and/or suffering, previously discussed or without my knowledge in the best interest of the patient.

I understand that a good faith effort has been made to create an accurate estimate for cost of services and products. I acknowledge that any financial estimate is ***accurate within a range of 15%.***

If a surgical procedure is authorized, I acknowledge that unexpected conditions may arise during the procedure. I grant the authority to remedy such unexpected conditions as seen fit by the attending veterinarian(s).

I acknowledge that the attending veterinarian and/or support staff will attempt to contact me before remedies are made.

Should I be unavailable, I authorize attending staff to act in the best interest of the listed animal with or without my verbal consent.

I acknowledge that no guarantees are made with regard to the outcome of any services rendered or product sold.

I accept full financial responsibility for fees related to services rendered by parties of PAW Health Network, Inc. and/or any products sold.

I agree to make an initial deposit and will remedy any remaining charges on my account upon completion of services.

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 release PAW Health Network, Inc., all owners, all employees, and all affiliates of liability, loss, damages, and/or compensation associated with the outcome of any services rendered by employees or agents of PAW Health Network, Inc.

ESTIMATE RANGE		**INITIAL DEPOSIT**
$____________	**-** **$**____________	**$**____________

In the event of a life-threatening medical, surgical or anesthetic crisis:

☐ I wish for CPR to be performed, I understand it could cost up to an additional $350

☐ Do not resuscitate my pet, I do not wish for CPR to be performed

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I certify that I have read and understand the contents of this release and consent

Signed ______________________________ Date ________________

I am providing **ONE phone number**, to be my/our primary contact phone number. I agree to be available at all times, with the ringer turned on. I/We may have conversations on speakerphone with multiple parties present, but I am responsible for disseminating information to all relatives and related parties. I understand doctors and staff do not have time to have multiple phone conversations with multiple parties while maintaining exceptional patient care.

Our ONE Primary Contact Phone Number Is ______________________________