bluepearl
specialty + emergency pet hospital

**OUR SERVICES**

Anesthesiology & Pain Management
Critical Care
Diagnostic Imaging
Emergency
Internal Medicine
Oncology
Surgery

## CLIENT INFORMATION

Owner name: _____ Spouse's name: _____

TX driver's license #: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Other phone: _____

Email address: _____

Would you like to opt in for our E-newsletter? ☐ yes ☐ no

We must be able to reach you. Please provide any number that will allow us to contact you or another responsible party. Thank you!

## PATIENT INFORMATION

☐ Dog ☐ Cat Name: _____ Patient #:_____

Breed: _____ Color: _____

☐ Male ☐ Neutered Male ☐ Female ☐ Spayed Female Age:_____ Years _____Months

Your Regular Veterinarian and/or Referring Veterinarian: _____

Hospital: _____

How did you hear about us? _____

Reason for visit: _____

Please list any other health problems: _____

_____

How do you wish to pay for services? We accept the following: ☐ Cash ☐ Personal Check ☐ MasterCard ☐ Visa ☐ Discover ☐ American Express ☐ Care Credit

****A consult fee of $120 will be charged at the end of your visit.*

Full payment is expected when the patient is released from the hospital**.**

**A DEPOSIT EQUAL TO THE LOW END OF THE ESTIMATED CHARGES IS REQUIRED PRIOR TO SURGERY OR HOSPITALIZATION.**

**Client signature: _____ Date: _____**

*Release: I am the owner of the above named pet, or am acting as the agent for the owner, and accept full financial responsibility. I give permission to proceed for any medical and/or surgical therapy as discussed and needed and agreed upon with the doctor(s). I give permission to release my pet's medical information to my referring or primary veterinarian(s).*