Returning Patient Information

bluepearl™
specialty + emergency pet hospital
bluepearlvet.com

Today's date _____

Client information

Name _____ **Spouse/partner name** _____

Address _____

Email address _____

Preferred method of communication (please mark):

☐ **Home phone number** _____ ☐ **Cell number** _____ ☐ **Spouse/partner phone number** _____

Driver license number _____ **State** _____

Patient information

Pet's name _____ **Date of birth or age** _____

☐ Canine ☐ Female ☐ Spayed

☐ Feline ☐ Male ☐ Neutered

Color _____ **Breed** _____

Current on vaccinations? ☐ Yes ☐ No

In the event of a life-threatening complication, do you want us to perform CPR on your pet? ☐ Yes ☐ No
(Additional charges will occur that will not be included on the estimate provided.)

Current medications _____ **Current allergies** _____

Reason for today's visit

☐ **Scheduled recheck per veterinarian instructions** ☐ **Same problem** (Please describe below what has changed) ☐ **New problem** (Please describe below)

_____

_____

_____

Primary veterinarian

Name _____

Clinic name _____

Phone number _____

Fax number _____

Additional veterinarian or specialist _____

BluePearl staff to complete

Client name _____ **Patient number** _____

Wt _____ **T** _____ **HR** _____

RR _____ **MMs** _____ **CRT** _____

BCS _____ /9 **Pain scale (0-4)** _____

Reception review _____ Initials **Technician review** _____ Initials

AUTHORIZATION: I hereby authorize BluePearl to examine, prescribe for, and/or treat the above described pet. I, as the owner or person acting on behalf of the owner, assume responsibility for all charges incurred in the care of this animal. I acknowledge a deposit will be required prior to diagnostic testing, treatment or surgery. Estimate may change upon changes in my pet's condition or medical needs. The balance of the bill is due upon the completion of my pet's visit. I certify that I am older than 18 years old and legally competent to sign this form.

Signature _____ **Date** _____