COLONIAL ANIMAL HOSPITAL

SURGICAL CONSENT FORM

Clients Name:_____ Pet's Name:_____

Surgical Procedure

__ Spay

__ Castration

__ Dental Scaling/Polishing/Extraction.
Extractions are additional. Do we have permission to extract diseased teeth? ___Yes, ___ No

__ Other: _____

Would you like a microchip implanted for identification during the procedure? ___ Yes, ___ No.

Would you like your pet's teeth cleaned during the procedure if time allots? ___ Yes, ___ No.

Medical History: Check all that apply

___ Heart Condition
___ Bleeding disorder
___ Respiratory disorder
___ Recent Estrus (Heat)
___ On Heartworm Prevention (If not will need Heartworm test)
___ Medication reactions: _____
___ Diabetes
___ Other: _____
_____

CONSENT FOR SURGICAL ADMISSION TO HOSPITAL

I am the owner or agent for the owner of the animal(s) described on this form and have the authority to execute this consent.
I request that the veterinarians, agents and employees of Colonial Animal Hospital perform the services which are necessary to the examination, medication and treatment of the animals specifically described and identified on this form.
I authorize the veterinarians on duty (and the assistants they designate) to examine the animal(s) and to administer medical treatment or emergency surgical treatment which is considered therapeutically and/or diagnostically necessary on the basis of the findings during the course of the examination. Therefore, I hereby consent to and authorize the performance of such procedure(s) as are necessary and desirable in the exercise of the veterinarian's professional judgment.
I further understand that any animal found to be infected with either external or internal parasites will be treated for same at my expense.
I understand that the treatment of the patient will be conducted with due care and in accordance with the prevailing standards of competency in Veterinary Medicine. I certify that no guarantee or assurance has been made as to the results that may be obtained through the course of treatment undertaken by the veterinarians, agent or employees of Colonial Animal Hospital.
I assume financial responsibility for all charges incurred to the patient for services rendered and understand that full payment is required upon discharge. In case of non-payment, I am aware that Colonial Animal Hospital will charge the cost of collecting the debt on the amount owed for services. This includes the collections company's charges, attorney's fees and interest of 1.5 % per month (18% annum).
I understand that a written estimate of charges is available within reasonable time at my request. I also consent to the release of medical information.

Signature:_____ Date:_____

Daytime contact phone: _____

Home phone: _____