



PATIENT DETAILS (PET):

Name of Pet: _____

Dog Cat Other (please specify): _____

Breed: _____ Colour: _____

Age or Date of Birth: _____

PLEASE CHECK ONE OF THE FOLLOWING:

Female Spayed Female Intact OR Male Neutered Male Intact

INSURANCE PROVIDER: No Yes (please specify): _____

Policy Number (if known): _____

REGULAR VETERINARY CLINIC: _____

By listing your veterinary clinic, you are authorizing all medical records of treatments performed at Paramount Animal Hospital to be sent to the party above.

CLIENT DETAILS (OWNER):

First Name: _____ Last Name: _____

Phone: _____ Email: _____

Unit #: _____ Address: _____

City: _____ Postal Code: _____

SECONDARY CONTACT

Friend or family member who may also bring the animal in.

By listing this contact, you are authorizing them to make medical/financial decisions for the patient.

First Name: _____ Last Name: _____

Phone: _____

I hereby grant permission to Paramount 24 hour Animal Hospital to potentially use my pet's photo and story for posting on social media and printed materials. I acknowledge that no personal or private details will be released.

Yes, you may take photos of my pet. No, please do not take photos of my pet.

How did you hear about us? _____

Signature: _____ Date: _____