



RIDGEWOOD animal hospital

3730 Astrozon Blvd. Colorado Springs, CO 80910 (719) 390-7387

Owner: _____
Last Name First Name Middle Initial

Spouse/Co-Owner: _____

Address: _____ City/State _____ Zip: _____

Primary Phone: _____ Spouse/Secondary Phone: _____

Email: _____

May we use your email as a form of communication? YES NO

Owner Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____

How did you hear about our hospital? _____

Pet Name: _____ Species: _____

Breed: _____ Color: _____ MALE or FEMALE

Spayed/Neutered? YES or NO Age/DOB: _____ Are Vaccines up to date? YES or NO

Is your pet currently on any medications? YES or NO, If YES, please list medicine and dose: _____

Previous Vet: _____ Does this pet have any allergies? _____

I hereby authorize the veterinarian to examine, prescribe, and treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges shall be paid at the time the services are rendered. If said pet needs to be hospitalized, I may be required to leave a deposit on estimated services and procedures and the remaining charges must be paid for at the time of release.

Payment is due at the time of services. Ridgewood Animal Hospital reserves the right to refuse and refrain from any services. By signing this form, you give Ridgewood Animal Hospital permission to have your pet's medical records released to us via fax, email or postal mail.

Signature of Owner: _____ Date: _____