

Double Churches Animal Clinic, P.C.
8365 Whitesville Rd
Columbus, Ga. 31904
(706)322-3232
www.doublechurchesanimalclinic.com
Standard Consent/Drop Off Form

Today's Date: _____

Client Name: _____ **Patient Name:** _____
Address: _____ **Species:** _____
Telephone: _____ **Breed:** _____
Sex: _____
Color: _____
Markings: _____
Birth Date: _____

I hereby certify that I am the owner of the above-named animal or am responsible for it and have the authority to execute this consent.

I hereby authorize the performance of the following procedure(s):

Please describe in detail any problems your pet is experiencing and for how long. For example, if your pet is limping, identify which leg is affected. _____

Please list any medications your pet is currently taking. _____

Is your pet having any problems: eating? y/n drinking? y/n urinating? y/n defecating? y/n
What food does your pet eat (table food, treats)? _____
How much per day? _____

Please check one of the following:

- Do whatever procedures the veterinarian recommends.
 Please call me after the veterinarian examines my pet and before any treatment is done.

I authorize sedation or pain relief for the examination or treatment of my pet if necessary (i.e. for x-rays or wound treatment):

Yes No/Call me first

You are to use all reasonable caution in the treatment of my pet, in which event, I will not hold the clinic liable for injury, escape or death. I understand that any unforeseen problem that develops while I am absent and my pet is in your care will be treated as deemed best by the veterinarian and I assume full responsibility for the expense of treatment. If I neglect to pick up my pet within 10 days of the date of discharge, you may consider that the pet is abandoned and are hereby authorized to make arrangements for my pet as Double Churches Animal Clinic, P.C. deems best.

(Signature of legal owner)

Phone # _____