



Arrival Time: \_\_\_\_\_ Apt: Yes: \_\_\_\_\_ No: \_\_\_\_\_

EMAIL US ANY MEDICAL RECORDS @

OsceolaAnimalEmergency@gmail.com  
Dolphinvet@gmail.com

*Please provide us with the following information so that we may provide you and your pet with the finest service possible.*

**Client Information**

Cornerstone Client ID# \_\_\_\_\_

Owner's Name \_\_\_\_\_ Co-Owner Name \_\_\_\_\_

Home Address \_\_\_\_\_ Apt# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Phone# \_\_\_\_\_ Secondary# \_\_\_\_\_

*We also require a copy of your Driver License for identification purposes.*

Driver's License# \_\_\_\_\_ Email \_\_\_\_\_

Cornerstone Patient ID# \_\_\_\_\_

**Patient Information**

Pet's Name \_\_\_\_\_ Species \_\_\_\_\_ Breed \_\_\_\_\_ Date of Birth/Age \_\_\_\_\_

Sex \_\_\_\_\_ Spayed/Neutered (CIRCLE ONE) Color \_\_\_\_\_ Any Know Allergies? \_\_\_\_\_

**Referring Veterinarian**

Primary Veterinarian \_\_\_\_\_ Phone# \_\_\_\_\_

How Did You Hear About Us? \_\_\_\_\_

**Authorization**

I hereby authorize Osceola Animal Emergency to render medical care for my pet(s) as deemed necessary by the veterinarian. I understand that no guarantee can be given to the outcome of treatments and take it as my responsibility to comprehend any risks involved. I agree to pay for the cost of all services to which I consent to by written or verbal estimate. I understand that a deposit is required before diagnostics and treatments can be initiated. I also understand that these charges are to be paid in full at the time of treatment and that a 100% deposit will be required for all procedures.

**Payment Policy**

Accepted forms of payment: Cash, Visa, Mastercard, Discover and Care Credit. We are unable to accept any checks, American Express or payment plans at this time. All fees are due upon discharge. Exam fees are required before examination. Exam fees are non-refundable. 100% of the estimate fees are due as a deposit before diagnostics and treatments.

**Clients Signature**

**Date**

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