Welcome to Our Hospital

It is our mission to enhance the lives of patients, clients, team members and referring veterinarians by promoting and providing the highest quality emergency and specialty veterinary care based on compassionate progressive medicine, exceptional service, continuous learning and rigorous communication standards.

5019 N. Sawyer Ave., Garden City, ID 83714 – tel 208.375.1600

CLIENT INFORMATION

First Name	Last Name		MI
Street address	City/State/Zip		
Home Phone	Work Phone		Cell Phone
Employer	Employer Phone	Employer address	
Secondary Owner/Emergency Contact	Home Phone	Work Phone	Cell Phone
E-mail	Social Security #	Driver's License # and Issuing state	

PATIENT INFORMATION

		DOG CAT OTHER:		
Pet Name		Species (please circle)		
MALE FEMALE	YES NO			
Sex	(neutered or spayed?)	Breed	Age	Color
Family Veterinarian and/or Hospital		Reason for visit		

Referred by: (please circle) phone book television family vet location family/friend other:___________

AUTHORIZATION FOR TREATMENT AND FINANCIAL POLICY

I am 18 years of age or older and do hereby authorize the veterinarians and/technicians to examine my pet and administer treatment as is considered necessary for my pet's condition. An estimate of care options will be discussed prior to any treatments. In life threatening situations, stabilizing care may be instituted upon arrival, but no invasive or diagnostic treatment will be undertaken until it has been discussed with me. I also authorize WestVet to fax or e-mail my pet's medical record to my family veterinarian for the purposes of sharing information only. I understand that WestVet may refuse services for any reason. Any pet left in the hospital for a period of 10 days or more will be considered abandoned under Idaho law.

________initials

I hereby release WestVet of all liability in the event of injury, bite, fall or other circumstance that might cause injury while I/my family members am/are a visitor or patron in the hospital. I assume all risks and will take all necessary precautions regarding safety in all non-public areas of the hospital for myself and my family.

________initials

I agree to pay for all services rendered on behalf of my pet at the time of release. An initial payment will be required for all hospitalized and surgical patients. We accept cash, checks w/valid driver's license, Visa, MasterCard and Care Credit (new Care Credit and Wells Fargo accounts are assessed a set-up charge). Returned checks will incur a $30 NSF fee. If cost is an issue, please discuss this with a client care specialist prior to treatment.

________initials

_______________________________________ Signature of owner or responsible agent

______________ Today's date

_____________ Time of arrival