Crossroads Veterinary Hospital

Today's Date:_____

Patient's Information:
Patient name:
Breed: Color:
Birthday: Sex:
Microchip Number:

Owner's Information:
Owner's Name: Cell:
Spouse/other: Cell:
Address:
Email:

Authorization:
I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume full responsibility for all charges incurred in the care of this animal. I understand that these charges must be paid at the time of release and that a deposit may be required for surgical treatment and/or boarding services.

Signature of Owner: **Date:**

We accept Cash, Check, Visa, Mastercard, Discover, and American Express