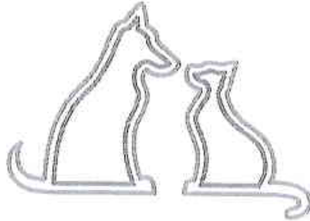

Animal Dermatology Center of Chicago

NAME________________________________ SPOUSE ________________________________

ADDRESS____

CITY/STATE____ZIP CODE__________________

HOME PHONE__________________________ WORK PHONE ___________________________

CELL PHONE_____________________________ E MAIL____________________________

DRIVERS LICENSE # (if paying by check) ____

EMPLOYER____________________________ ADDRESS ______________________________

REFERRED BY: ____

PRIMARY VETERINARIAN: ____

CLINIC NAME: ____

ADDRESS: _____________________________PHONE NUMBER:_______________________

PET'S NAME: ___________________________ SPECIES: ____________________________

SEX: _________________________________ BREED: _______________________________

COLOR: ____________________ BIRTHDATE: _____________________ WEIGHT: __________

THE ANIMAL DERMATOLOGY CENTER OF CHICAGO SPECIALIZES IN THE TREATMENT OF ALLERGIES, EARS, AND SKIN DISEASES ONLY. IF YOUR PET HAS ANY OTHER MEDICAL OR SURGICAL NEEDS YOU SHOULD CONSULT WITH YOUR PRIMARY CARE VETERINARIAN.

ALL FEES ARE DUE UPON RELEASE OF YOUR PET. ANTIGENS MUST BE PAID FOR WHEN ORDERED SINCE THEY ARE CUSTOM MADE FOR YOUR PET. WE ACCEPT CASH, PERSONAL CHECKS, MASTER CARD AND VISA.

AS LEADERS AND TEACHERS IN THE VETERINARY MEDICAL FIELD, CASE INFORMATION AND/OR PHOTOS MAY BE USED IN TEACHING, FORMS, CONTINUING EDUCATION, WEBSITE, VETERINARY LITERATURE, AND THE LIKE. I AUTHORIZE THE RELEASE OF CASE/PATIENT INFORMATION FOR SUCH PURPOSES; CLIENT CONFIDENTIALITY (NAMES WITHHELD) IS ALWAYS MAINTAINED.

I UNDERSTAND THAT NO GUARANTEE CAN BE MADE AS TO THE RESULTS OBTAINED FROM MEDICAL TREATMENT. FURTHER, I ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED BY THE PATIENT.

____ DATE ____________________

Signature of Owner or Responsible Agent