



4020 South Babcock Street Melbourne, FL 32901 Animal-Medical-Clinic.com

Owner:		Pet's Name:			
I am the owner of the above name	ed animal or am responsible for it and h	ave authority to execute this consent. I am	over eighteen years	of age.	
I authorize the performance of the	following procedure(s):				
procedures that the doctor deems advisable in the performance of s small but real possibility of side e	s advisable for the health, safety or wel uch surgical, diagnostic or therapeutic	uthorize the doctor and staff to administer a I being of my pet. I also authorize the use o procedures. I realize that the admnistration the nature of the procedure(s) being perfo	of such anesthetics of any anesthetic ag	as you deem jent carries a	
I understand that at ni	ght there may be times when there will	not be anyone here with my pet.			
I acknowledge that no	acknowledge that no guarantee or assurance has been made as to the results that may be obtained.				
	I agree to indemnify and hold Animal Medical Clinic and its doctors and employees harmless from and against any and all liability arising out of the performance of any of the procedures referred to above.				
Treatment Consent Would you like to have a m	icrochip placed in your pet?		Yes 🕾	No 🕾	
Does your pet require a spo	ecial diet? bring some of the food with yo	our pet	Yes 🕾	No 🕾	
What time did your pet last eat?			am pm		
What medications is your p	pet taking and when was it last (given (Include Over-the-Counter Me	edications)?		
(Please bring any medical	tions with your pet)				
Signature:		Date:			
How would you like us t	o contact you today with up	dates?			
Phone Call	Text Message	Phone Number:			
E-mail	E-mail Address:				