



IronHorse VetCare New Client Registration Form

7660 Amador Valley Blvd Suite E Dublin, C 94568

Date/Time: _____

Reason For Today's Visit:

Primary Owner Email:

Have you visited Ironhorse Vetcare previously?

Primary Owner Phone:

Yes

No

Primary Owner First/Last Name:

Primary Owner Date of Birth:

Owner's Street Address

City

State

Zip Code

Make/Model/Color of Car: _____

Secondary Owner Name: _____

Secondary Owner Phone & Email: _____

Patient Name: _____ Breed & Color: _____

Sex:

Species:

Male

Canine

Female

Feline

Spayed Female

Other

Neutered Male

Patients Date of Birth/Approximate Age: _____

Patients Primary Veterinarian: _____

I grant permission to release records for the following stated purposes: We are leaders and teachers in the field of veterinary medicine. Medical files, thus case information, and/or photos may be used in teaching, forms, continuing education, website, social media, veterinary literature, and the like.

Yes

No

I grant permission for medical records to be shared with the family veterinarian of record. I authorize the release of case/patient information for such purposes; client confidentiality (names and personal information) will be maintained in cases other than contact with referring veterinarians.

- Yes No

I grant permission for medical records and financial statements to be shared with the Insurance Company of record. I authorize the release of case/patient information including names , personal information, and patient information.

- Yes No

Should my pet require cardiopulmonary resuscitation (CPR), including cardiac compressions, intubation, positive pressure respiration, emergency drugs, and other heroic interventions deemed medically necessary:

- Yes, I request that the veterinarian(s) at IronHorse VetCare Hospital pursue such medical care as indicated. I understand that the costs associated with these procedures are not included in my original estimate. I agree to pay for such services.
- No, I decline CPR, emergency drugs, or any other heroic interventions.

If a medication is initially prescribed by this office and prescribed, dispensed, or furnished to me, it is my right to receive in person or through electronic means, a consultation that includes the following information: Drug name and description of the dangerous drug, route of administration, dosage form, dosage, duration of drug therapy, the duration of the effects of the drug and the common severe adverse effect associated with the use of a short-acting or long-acting drug. Any special directions for proper use and storage. Actions to be taken in the event of a missed dose. If available, precautions and relevant warnings provided by the drug's manufacturer, including common severe adverse effects of the drug. A veterinarian may delegate to a registered veterinary technician or veterinary assistant the task of providing the consultation and drug documentation required by this section.

- I would like to receive additional paper regarding dangerous drugs
- I would like to receive additional digital documentation regarding dangerous drugs.
- I decline additional information.

I understand that all charges/fees are due at time of service. I agree to pay all fees for all services rendered at the time my pet is discharged from Ironhorse Vetcare.

- Yes

Primary Owner Signature:

How did you hear about us?

- | | |
|---|--|
| <input type="checkbox"/> Primary Care Veterinarian (rDVM) | <input type="checkbox"/> Yelp |
| <input type="checkbox"/> Social Media (Facebook, Instagram) | <input type="checkbox"/> Public Events |
| <input type="checkbox"/> Referred from another Client | <input type="checkbox"/> Google |