Clover Park Veterinary Hospital
6129 100th St. SW
Lakewood, WA 98499
253.588.6649
Email: villm@cloverparkvet.com

AUTHORIZATION FOR PROFESSIONAL SERVICES

The following information is necessary in order to serve you better and give you more personal service. Please fill out the information completely.

The nature of such services, including the indications, benefits, and risks of anesthesia has been described to me to my satisfaction. I realize that no guarantee or warranty can ethically or professionally be made regarding results or cure.

I understand that I assume financial responsibility for all services rendered and that payment is due on the date of the procedure.

Owner_____ Pet's Name_____

Canine ☐ Feline ☐ Male ☐ Female ☐ Birthdate_____

I hereby authorize the following surgery/procedures: *Please select all that apply*

Exam ☐ Spay ☐ Neuter ☐

If pregnant, I want: Notification ASAP ☐ Surgery Stopped ☐ Fetuses aborted ☐

Declaw ☐
(front only) Pain medication required over 7 lbs

Dentistry:

Teeth cleaning/prophy ☐

Tooth Extractions ☐
extra charge may apply

Vaccinations:

Dog: DHLPP-CVK ☐ Rabies ☐ Kennel Cough ☐

Cat: FVRCP-C ☐ Rabies ☐ FeLV ☐ FELV/FIV test ☐
(ask at desk if a new pet)

Microchip Nail Trim Fecal Test
(check for worms)

*Other*_____

Would you like pain medication for your pet after surgery? Yes ◉ No ○ Other_____

Please leave us a phone number that you can be reached at durning the day:

Daytime Phone _____Work_____Cell _____

Signature_____ Date_____