Inland Empire Veterinary Imaging

Patient Registration Form

For office use: Abdominal Cardiac Urinary ☐ MO ☐ Report ☐ CO ☐ CV

Please complete the following information:

Name: ____

Address: ____

City: ________________________

State: ________________________ Zip: ____________

Home Phone: ____________ Alternate Phone / Cell ph: __________

Employed by: _______________________________________

Address: __________________________________ Work Phone:________

Email address: ____

Pet Information:

Name: __________

Circle one: Canine Feline

Breed: __________________

Sex: __________ Spayed/Neutered: Yes: ________ No: ________

Age: __________

Regular Veterinary Clinic:____**Veterinarian**:______________________

I hereby authorize Drs. Ramirez/Siems and assistants to perform diagnostic imaging services on my animal. If my animal is uncooperative in preparation for ultrasound examination or for the ultrasound examination itself, I then authorize Drs. Ramirez/Siems or his assistants to sedate my animal. Should general anesthesia be necessary, I understand there are potential risks, including the possibility of death of my animal. I also certify that no guarantee has been made as to the results that may be obtained. I consent to release all medical information. I hereby certify that I have read and understand the above authorization.

PROFESSIONAL FEE POLICY: Fees are to be paid at the time of service. Please indicate method of payment.

Cash:__________ Check:__________ Credit Card:__________

SIGNATURE:____**DATE**:______________________

Aspirate Approved ________________ **Biopsy Approved**___________________ **Tap Approved** __________________