

Kettle Moraine Veterinary Clinic

2712 Eastern Ave. · P.O. Box 439 · Plymouth, WI 53073 · (920)892-4225

Date _____

Owner Information

First:	Last:	M.I.:
Mailing Address:		
City:	State:	Zip:
Home Phone:	Cell:	Work:
Email:	Employer:	
Add'l Owner(s):		
Mailing Address:		
City:	State:	Zip:

Patient(s) Information

Pet Name: _____ Canine / Feline	Pet Name: _____ Canine / Feline
Pet Name: _____ Canine / Feline	Pet Name: _____ Canine / Feline
Pet Name: _____ Canine / Feline	Pet Name: _____ Canine / Feline

Agent Information

Yes No Other than you and any additional owner(s) listed above, are there any other persons to whom you give primary responsibility for the care of the patient? If **"Yes,"** please list below. All authorized agents must be 18 years of age or older.

1. Name _____	Phone: _____
2. Name _____	Phone _____
3. Name _____	Phone _____

I understand that my veterinarian will need to communicate with me, or someone designated by me, prior to treatment of my pet(s) in order to obtain informed consent. For purposes of obtaining informed consent, I direct my veterinarian as follows:

Informed consent may ONLY be provided by an owner. Yes No
 Informed consent may be provided by the agent(s) listed above: Yes No

(This included authorizing all medications, treatments, hospitalizations, sedation, anesthesia, surgery, and euthanasia. **The authorized agent will be responsible for all incurred costs.**)

Signature: _____ Print: _____ Date: _____

Office Use							