

Welcome To



Personal Information

Owner's Name _____
(Last) (First) (Initial)

Spouse/Co-Owner _____
(Last) (First) (Initial)

Driver License # _____ SS# _____ Spouse/Co-Owner SS# _____

Address _____

City/St./Zip _____

Phone: Home _____ Cell _____ Email _____

Place of Employment _____

Employment Phone _____ Spouse Employment phone _____

Relative/Friend _____ Phone _____

(If we are unable to reach you in case of an emergency)

When is the best time and day to reach you? _____ Which # is best? _____

How did you learn about our practice? Family/Friend _____ Doctor _____

Phonebook Radio Internet/Website Angie's List _____ Other _____

Patient Information

Pet's Name: _____ Age/Birth date: _____

Sex: Female/Spayed _____ Male/Neutered _____ Breed: _____ Color: _____

List any chronic health problems? _____

Is your pet on any current medications/special diets? _____

Any known drug allergies? _____

What type of Heartworm Preventative are you using? _____

What type of flea and tick Preventative are you using? _____

What type of pet food are you feeding? _____ What kind of Treats? _____

Name of Previous Veterinarian/Vet Hospital: _____

DATES OF LAST VACCINATIONS

Dog

DHL-P _____

RABIES _____

PARVO _____

KENNEL COUGH _____

Cat

FVRCP _____

RABIES _____

FELVB _____

FIP _____

Payment Information Circle Form of Payment desired.

****PAYMENT IS EXPECTED AT THE TIME OF SERVICES RENDERED****

Cash

Care Credit

Debit

MasterCard

Visa

Discover

Sorry, we do not accept checks

Please let us know prior to your visit if an **estimate** was given. The end cost may actually be lower or possibly higher depending upon each individual circumstances.

To prevent the spread of infectious diseases all hospitalized patients must be current on required vaccines and free from internal and external parasites. The signature below authorizes this level of preventative care and the appropriate charges will be assessed in the discharge invoice.

I acknowledge that all payments are due at the end of every service. I agree to pay the entire balance for all services rendered at time of discharge.

Name: _____ Date: _____



LATE/MISSED APPOINTMENT POLICY

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality of care, it is very important for each scheduled patient to attend their visit on time. If it is necessary to reschedule the appointment, please call us as soon as possible.

As a courtesy, a reminder call will be made/attempted the day before your pet's appointment.

If you are unable to call the office 2 hours in advance of your appointment or you are more than 15 minutes late to your appointment, your account will be subject to a charge of \$10.

Please understand your scheduled appointment is the time we set aside for your pet to see the doctor. We understand changes in your schedule or unexpected emergencies can arise that make your appointment inconvenient. If we receive adequate notice to cancel or reschedule your appointment, the doctor can potentially take care of another pet in need.

I have read and agree to comply with the above policy.

Client Signature

Date