

# 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  MarketPlace Magazine  Internet/Website  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? \_\_\_\_\_  
 Where were the last vaccinations given? \_\_\_\_\_  
 What doctor gave the vaccinations? \_\_\_\_\_

### DATES OF LAST VACCINATIONS

<b>Dog</b>	<b>Cat</b>
DHL-P _____	FVRCP _____
RABIES _____	RABIES _____
PARVO _____	FELVB _____
KENNEL COUGH _____	FIP _____

## Payment Information

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

Check Form of Payment desired

Cash	Check	Care Credit	MasterCard	Visa Discover
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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 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: \_\_\_\_\_