

| □ New Client □ New Pet □ Yearly Update | | | |
|--|---------------------------|---|---------------------------------|
| Last Name: | _Middle Initial: | First Name: | |
| Address: | City: | State: | Zip: |
| Address: Phone (Cell): Phon | e (Home): | Phone (Work): | |
| Preferred method of contact: First Choice: | Phone Call (Cell) D Pho | one Call (Home) 🛛 Text Message 🗆 | Other: |
| Second Choice: Phone Call (Cell) Phone Call | all (Home) 🗆 Other (pleas | se specify): | |
| E-Mail Address: | | | Please Rest |
| assured that we will only send you information relev | ant to you and your pet (| i.e. vaccination reminders, etc.) and v | will not be sold or distributed |
| Spouse Name: | Spo | use (Cell): | |
| Emergency Contact Name & Relation: | | Contact (Cell): | |
| Are you over the age of 60 and a current ca | | | |
| Do you have a valid Care Credit™ Card and | | | |
| Do you have a valid driver's license? Ves | | | |
| Referred by: Location Dolline Doctor / Cl | | | vspaper |
| □ Brochure / Flyer □ Phone Book □ Friend / Clier | | - | |
| Method(s) of Payment: Cash Check Visa/ | | | |
| | | | |
| Pet Name: | | Pet Information me: | |
| Pet Name: | Pet Na | | |
| Date of Birth (MM/DD/YY): | | | |
| Species: Cat Dog Avian Ro | | es: Cat Dog Avian | |
| Other: Prood: | | r: | |
| Breed: | | | |
| Color: Sex: Spayed Neutered | Color | □ Spayed □ N | eutered |
| Does your pet currently on any medications (if | | /our pet currently on any medication | |
| list name/dosage) or have any known reactions | | me/dosage) or have any known rea | |
| or chronic medical conditions? If so, please ex | - | onic medical conditions? If so, ple | - |
| ·• | · | | • |
| | | | |
| | | | |
| When and where were your pet's last vaccination | | and where were your pet's last vac | |
| obtained? | obtain | ed? | |
| Please check any of the below symptoms/prob | lems vour Please | check any of the below symptom | s/problems your |
| pet is experiencing (if any): | | experiencing (if any): | |
| □ Behavioral □ Depression □ Breathing Difficulty | | vioral Depression Breathing Di | |
| □ Loss of Balance □ Limping □ Constipation □ Vo | | of Balance Limping Constipatio | - |
| □ Coughing/Sneezing □ Weakness □ Change in U | | hing/Sneezing | |
| □ Appetite Change □ Ear Infection(s) □ Lumps/Bu | | tite Change \Box Ear Infection(s) \Box Lu | • |
| □ Change in Thirst □ Eye Infection(s) □ Bad Breat | | nge in Thirst \Box Eye Infection(s) \Box Ba | |
| □ Scratching □ Hot Spot □ Bleeding □ Other: | | tching | |
| Is your pet: Indoors Outdoors Both | | pet : Indoors Outdoors Both | |
| How many and what kind of other pets do you h | | any and what kind of other pets d | o you have at |
| home (if any)? | | (if any)? | • |

I have carefully read this release in its entirety, understand it, and sign it voluntarily. I attest that I am over 18 years of age, am legally competent and am not a minor in my state of residence. I hereby authorize the veterinarian(s) to examine, prescribe for, and/or treat the above described pet(s). I assume all financial responsibility in the care of the above animal(s). I also understand that these charges must be paid in full at the time of discharge. All unpaid balances will be subject to a 1.5% service charge per month and legal action. Should my check be returned I agree to pay the original amount in addition to a \$30.00 returned check fee.