

Welcome to Pet Medical Center



Owner's Information

Last Name _____ First Name _____ Middle _____
Address _____ City _____ Zip _____
Home Phone _____ Mobile Phone _____
DL# _____ S.S.# _____ DOB _____
Employer _____ Work Phone _____
Email Address _____

Spouse/ Co-Owner's Information

Last Name _____ First Name _____ Middle _____
Home Phone _____ Mobile Phone _____
DL# _____ S.S.# _____ DOB _____
Employer _____ Work Phone _____
Email Address _____

Please list other persons that you authorize to act on behalf of your pet(s): _____

Previous Veterinarian

Hospital Name _____ Phone _____

Referred by _____ (Please provide their name so we may thank them)

or choose one:

Yellow Pages

Website/ Internet

Drive By/ Sign

Other _____

Pet's Information

Pet Name _____ DOB/ Approx. Age _____

Species: Canine Feline Breed _____ Color _____

Sex Male

Female

Spayed/ Neutered? YES

NO

Allergies: _____

Current Medications: _____

Special Diet: _____

Vaccines last given _____

Pet Name _____ DOB/ Approx. Age _____

Species: Canine Feline Breed _____ Color _____

Sex Male

Female

Spayed/ Neutered? YES

NO

Allergies: _____

Current Medications: _____

Special Diet: _____

Vaccines last given _____

I hereby authorize Pet Medical Center to examine, prescribe for, and treat the above described pet(s). **Payment in full is due at the time services are rendered.** Printed estimates for services recommended by the veterinarian can be provided upon my request. I understand that veterinary service during nighttime hours and/or weekends is provided at the discretion of the veterinarian in charge. Continuous presence of personnel may not be provided during these hours.

Signature of Owner/ Agent _____ Date _____