Signature of Primary Owner: Date: \_\_\_

Signature of Spouse/Co-Owner: Date: \_\_\_

**Payment Policy/ Treatment Authorization**

All fees are due upon completion of the visit. We accept cash payments and most major credit cards. **NO CHECKS.** **I authorize treatment of my pet(s). I understand that pet must be current on rabies vaccine for ANY treatment.**

**Do we have permission to post your pet’s story/pictures/reviews on our social media?  YES  NO**

**Patient Information**

Pet Name: DOB/Age: Sex: \_\_\_

Breed: Spayed/Neutered:  Yes  No

Color/ Markings: Date of Last Vaccines: \_\_\_

Clinic/Shelter Name & Phone # where previously seen: \_\_\_

Pet Name: DOB/Age: Sex: \_\_\_

 Cat  Dog Other: \_\_\_ Breed: Spayed/Neutered:  Yes  No

Color/ Markings: Date of Last Vaccines: \_\_\_

Clinic/Shelter Name & Phone # where previously seen: \_\_\_

**Client Information**

First Name: Last Name: Date: \_\_\_

Spouse/Co-Owner Name:

Physical Address: \_\_\_

Mailing Address: \_\_\_

City: State: Zip Code:

Home Phone #: Cell Phone #: ­­­\_\_\_ \_ Work Phone #: \_\_\_

Driver’s License #: Check One:  Military/Veteran  Senior  N/A DOB: \_\_\_

Email Address: \_\_\_