Spooner Veterinary Clinic

Care Animal Clinic

PRIMARY OWNER(S):

Name:_____ Spouse:_____

Address:_____ City:_____ State:_____ Zip:_____

Primary Phone:_____ Is this a CELL PHONE or HOME PHONE (circle one)

Cell Phone:_____ Work Phone:_____ Email:_____

Preferred method of payment: Cash_____ Check _____ Credit/Debit _____ Care Credit _____

How did you find out about our clinic? _____

Other than you/your spouse, are there any other person(s) to whom you give permission to make treatment decisions for your pet? YES_____ NO_____

If you have checked yes, please list the name and telephone number of the person(s) you have authorized to consent for treatment:

_____

_____

I give the Doctors of Spooner Veterinary/Care Animal Clinic my permission to stabilize my pet in an emergency situation if I am not present/available and they are unable to reach any individual listed above. YES_____ NO_____ (If NO, please explain your preference_____)

The above information is applicable to all of my pets: YES____ NO_____

PATIENT INFORMATION:

Name							
Breed							
Date of Birth/Age							
Color							
Sex	Male	Female	Male	Female	Male	Female
Spay/Neuter	Neutered	Spayed	Neutered	Spayed	Neutered	Spayed

Any previous surgeries or serious illness? _____

Any allergies to vaccines or medications? _____

Is your pet on a special diet, medication, and/or supplement? _____

ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED

I agree to adhere to the terms set forth in this agreement. All services rendered must be paid in full at the time of service. If full payment is not made, the remaining balance will incur a 2% monthly service charge and a minimum $1.00 invoicing fee for each month thereafter. After 60 days, the clinic will consider the balance in default and the account will be turned over to collections.

By signing this, I verify that I have read and understand the content of this form.

Signature:_____ Date:_____