CLIENT INFORMATION
CID:_____

Thank you for giving us the opportunity to care for your animal(s).
Please fill out the following form completely.

Owner's Name:_____ **Spouse:**_____

Additional person(s) authorized to make medical decisions:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Phone #: (_____)_____ Spouse/Alt. Phone #: (_____)_____

Email Address:_____

Owner's Driver's License #:_____

Issuing State:_____ Date of Expiration: _____

Employer: _____

Employer Address: _____

Work #: (_____)_____ Ext. _____

How did you hear about us?

- ☐ Referral:_____
- ☐ Social Media
- ☐ Drove by
- ☐ Yellow Pages
- ☐ Other: _____

Upon request, we will gladly prepare an estimate before any services are performed.

*__Due to state law and insurance requirements, all dogs and cats must be current on Rabies vaccination.__ Vaccination can be updated at the time of your appointment if it is not current.

The Village Veterinarian is asking for permission to use photographs taken by staff for use of social media, publications, news releases, online, and in other communications related to our mission.

☐ **Allow Permission** ☐ **Decline Permission**

Acknowledgement of Ability to receive Written Prescriptions:
I understand my right to receive a written prescription for medication that can be filled at the pharmacy of my choice or by my veterinarian, as provided in s. 474.224, Florida Statutes.

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat, and/or perform surgery upon the pet(s) listed on the following page(s). Furthermore, I agree to pay any fees for services rendered at the time the pet is discharged from the hospital. I agree to pay for the costs of collection, in the event that collection efforts become necessary. I understand that a service fee of $25.00 will be assessed for each non-sufficient fund check and/or certified letter that must be sent.

Signature: _____ **Date:** _____

PATIENT INFORMATION

Pet Name: _____ **Owner's Last Name:** _____

Pet's DOB: ____/____/_____ Species: ☐ K9 ☐ Feline

Breed: _____ Gender: ☐ Male ☐ Spayed ☐ Female ☐ Neutered

Color/Markings: _____

Is your pet microchipped? ☐ Yes ☐ No

If so, what is their microchip number? _____

Previous Hospital/Clinic: _____

Address: _____ **State:** _____ **Zip:** _____

Phone #: (____) _____

May we call to get your pet's records? ☐ Yes ☐ No

Are your pet's vaccines up to date? ☐ Yes ☐ No

Is your pet on heartworm prevention? ☐ Yes ☐ No

*If yes, what kind, and when was it last given? _____

Is your pet on flea prevention? ☐ Yes ☐ No

*If yes, what kind, and when was it last given? _____

What brand of food does your pet eat: _____ Amount Fed: _____

Does your pet get treats: ☐ Yes ☐ No

If your pet is on any medication, please list them below:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 5. _____

Please list any other history (prior illness or surgeries): _____

_____

Signature: _____ **Date:** _____