ANIMAL MEDICAL CLINIC

M. Scott Smith, DVM

PET'S NAME________________________SEX_______AGE_________BIRTHDATE____________

NEUTERED?_________CAT_____DOG_____BREED_____________________COLOR____________

VACCINATION/MEDICAL HISTORY:

CAT: Distemper_____/____ Leukemia_____/_____ Rabies_____/_____ Leukemia Test?_____________

WHEN WHEN WHEN RESULT

DOG: Distemper/Parvo______/_____ Corona______/____ Rabies______/______ Bordatella______/______

WHEN WHEN WHEN WHEN

PAST MEDICAL PROBLEMS OR ALLERGIES?____

____

HOW DID YOU FIND OUT ABOUT THE ANIMAL MEDICAL CLINIC?

____

OWNER____ ____________________

LAST FIRST HOME PHONE

E-MAIL: ____ _______________________

CELL PHONE

ADDRESS____

STREET CITY STATE ZIP

OCCUPATION_____________________________ EMPLOYER_________________________________

WORK ADDRESS____ _________________

STREET CITY ZIP WORK PHONE

SPOUSE_____________________________________ EMPLOYER______________________________

LAST FIRST

WORK ADDRESS____ _________________

STREET CITY ZIP WORK PHONE

I UNDERSTAND THAT PROFESSIONAL FEES ARE TO BE PAID AT THE TIME THEY ARE RENDERED.
I AUTHORIZE TREATMENT FOR MY ANIMALS AND ACCEPT RESPONSIBILITY FOR THE CHARGES INCURRED IN THIS HOSPITAL.

SIGNED____ Dated______________________

OWNER OR OWNER'S REPRESENTATIVE

DRIVER'S LICENCE___________________________

THERE WILL BE A $15.00 SERVICE CHARGE FOR RETURNED CHECKS