Singing River Animal Clinic

PATIENT/CLIENT INFORMATION

Welcome to Singing River Animal Clinic. Thank you for giving us the opportunity to care for your pet. Please help us meet your needs better by taking a moment to complete both pages of this information sheet.

Owner's Name:_____Spouse/other:_____

Address:_____City_____State___ _____Zip_____

Is your mailing address different from your physical address? If so please list here:

_____

Email address:_____Spouse/Other Email:_____

Cell # (owner) _____Cell #2 (spouse/other) _____ Home # _____

May we contact you at work? Yes / No Work # _____ ext_____

Employer's Name/Address:_____

Spouse/Other's Employers Name/Address: _____

How did you first learn of our hospital? ☐ Hospital Sign ☐ Internet/Website

☐ An individual we may thank: _____

☐ Other: _____

We will gladly prepare an estimate for you upon request.

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

We accept Cash, Check, Visa, MasterCard, Discover, Care Credit ($200 minimum) and Debit cards.

Deposits may be required for pet's being admitted. We require a DRIVER'S LICENSE NUMBER on file:

Driver's license #_____State issued _____DOB_____

This information will be kept strictly confidential.

Consent to Treatment and Financial Responsibility

I hereby authorize Singing River Animal Clinic to examine, prescribe for, and treat my pet(s). I further authorized Singing River Animal Clinic to provide vaccines as needed for my pet(s) to comply with all applicable laws. I understand that Singing River Animal Clinic cannot guarantee success of any treatment provided for my pet(s), and that I am responsible for payment of all charges incurred regardless of the results, at the time services/treatments are rendered.

OWNER SIGNATURE_____**DATE**_____

(Form continues on back)

Animal Identification and Medical Information

Name of Client: _____please complete **ALL** information for each NEW pet.

	Pet #1	Pet #2	Pet #3
Pet's Name			
Species			
Breed			
Description / Color			
Date of birth/ Age			
Sex: F/M			
Spayed/Neutered			
Length of time owned			
How/Where did you acquire your pet?			
Microchip #			
Heartworm/Internal parasite prevention product used			
Flea/Tick Prevention used			
Current Medications			
Diet			
Prior Illness/Injury			
Prior Surgery/Dentistry			

Do you have any prior vaccine history with you? Yes No
(If so, please give records to the customer service representative to make a copy for your pet's records, or email records to SRACAnimals@gmail.com)

If not, may we call your pet's previous veterinarian and request a copy of records to be made part of your pet's permanent record here? Yes No

Previous Veterinarian: _____
Address: _____
Phone #: _____

Additional Comments: _____
_____