WELCOME to ANIMAL MEDICAL CARE

We appreciate your trust and will do our best to care for the needs of your pet

CLIENT INFORMATION:

Date: _____ Driver's License or Social Security #_____
Last Name: _____ First Name: _____
Spouse's Name: _____
Address: _____
City, State and Zip: _____
Cell Phone: _____ May we send you text messages: _____
Home Phone (If applicable): _____ Email Address: _____
Work Number: _____ Employer: _____
How did you hear about our practice? Who may we thank? _____
Please initial if we do NOT have your permission to post your pets photos on our Facebook/Instagram _____

PET INFORMATION:

Pet's Name: _____

- ☐ Dog
- ☐ Cat
- ☐ Other _____

Sex:

- ☐ Male / Neutered? Yes _____ No _____
- ☐ Female / Spayed? Yes _____ No _____

Birthdate or approximate age: _____ Breed: _____
Color: _____

PAYMENT: I assume responsibility for payment. I understand that payment is expected at the time of discharge. We accept cash, checks, and all major credit cards including Care Credit.

AUTHORIZATION:

I, the undersigned owner or authorized agent of the above patient, hereby authorize the Doctors of Animal Medical Care to examine, perform diagnostic and treat as necessary. I understand that no guarantee of successful treatment is made. Estimates will be given upon request.
Signature of Owner_____

Do you give consent for us to send your pet's medical records if they are requested? YES_____ NO_____