**Our mission at VCA Schaumburg Animal Hospital is to maintain wellness in animals and the people that interact with them. By providing us with the requested information about you and your pets, you are partnering with us to achieve this mission! Thank You**

Owner 1 - First Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Owner 2 - First Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip : \_\_\_\_\_\_\_\_\_\_ County : \_\_\_\_\_\_\_\_\_\_ State : \_\_\_\_\_\_\_

Phone Numbers:

Home : (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work : (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell : (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you find us?** (Whom may we thank?) **Please Circle**

Personal Referral: (Client’s Last name, Pet's name) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rescue/Foundation Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drive By

YellowPages.com Google LocalVets.com Yelp.com Angieslist.com

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for exam, treatment, and assumption of financial responsibility:**

I hereby authorize the veterinarian to examine, prescribe for and/or treat above named pets. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid immediately upon completion of the services rendered and that if hospitalization or surgical intervention is necessary a deposit may be required. To maintain wellness in the pets being treated in our hospital, all hospitalized and boarded animals must be current on vaccinations, external parasite control, and fecal test.

**Please circle which form of payment will be used: NO CHECKS**

**Cash Debit MasterCard Visa AmEx Discover CareCredit**

**Owner/Agent Signature :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date : \_\_\_\_\_\_\_\_\_\_**

**Receptionist/Tech Initials\_\_\_\_\_\_**