



Client / Pet Information Sheet

Owner's Name: _____

Last Name
First Name
MI
Spouse / Co-Owner's First Name

Address: _____

Number
Street
Apt #
City
State
Zip

Phone Numbers: _____

Home
Work
Other

E-mail: _____

Referred By: Yellow Pages (book) Yellow Pages (internet/website) Hospital Sign Newspaper

Client: _____ Veterinarian: _____

Humane Society/Pet Store: _____ Other: _____

D.O.B.: _____ Employer: _____ Employer's Address: _____ _____ City: _____ State: _____ Other Information: _____	D.O.B.: _____ Employer: _____ Employer's Address: _____ _____ City: _____ State: _____ Other Information: _____
---	---

Pet's Name: _____ Species: _____ Breed: _____

Color: _____ Sex: M F Altered Birth Date: _____

Vaccination/Booster Shot Date: _____ Microchip/Tattoo #: _____

Pet's Name: _____ Species: _____ Breed: _____

Color: _____ Sex: M F Altered Birth Date: _____

Vaccination/Booster Shot Date: _____ Microchip/Tattoo #: _____

Pet's Name: _____ Species: _____ Breed: _____

Color: _____ Sex: M F Altered Birth Date: _____

Vaccination/Booster Shot Date: _____ Microchip/Tattoo #: _____

Please Sign The Following Authorization For Treatment

I hereby authorize the staff of VCA to render any treatment that is deemed necessary to my pet(s) health while in custody of the hospital. I understand that in the event of any unusual or emergency circumstances, the staff will make every attempt to contact me or my designated representative before, if time permits, proceeding with treatment. I understand that I will be financially responsible for all emergency procedures including the Estimate of Charges provided to me in person or over the telephone. **I understand that professional fees are to be paid at the time services are rendered and a deposit is required on all pets admitted to the hospital.**

Signature of Owner, Agent, or Good Samaritan Date Signature of Spouse Date

Please Circle Your Method of Payment Cash Check Visa MasterCard Discover American Express