



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