

ANIMAL MEDICAL & SURGICAL CENTER

Welcome! We appreciate the opportunity to serve you and your pets

DATE _____ REASON FOR TODAY'S VISIT _____

OWNER'S NAME _____ SPOUSE/OTHER _____

ADDRESS _____
Street/P.O. Box City State Zip

HOME PHONE _____ WORK PHONE _____

In case of emergency, contact _____ *at* _____



1. PET'S NAME _____ Birth date _____ BREED _____

[] Dog [] Cat [] Bird [] Other _____ COLOR _____

[] Male [] Female [] Neutered Male [] Spayed Female

2. PET'S NAME _____ Birth date _____ BREED _____

[] Dog [] Cat [] Bird [] Other _____ COLOR _____

[] Male [] Female [] Neutered Male [] Spayed Female

DO YOU HAVE MORE THAN 2 PETS? PLEASE LIST ON BACK

Previous veterinarian (*if none, please indicate N/A*) _____

Type of heartworm prevention _____ Type of flea control _____

Allergies _____

Any illnesses in the past year [] no [] yes, please specify _____

How did you FIRST hear of Animal Medical & Surgical Center? _____

If you were referred, please let us know whom we may thank _____

As the owner or agent for the owner, I assume full responsibility of all charges incurred for the care of my animals. I also understand that all charges will be paid at the time of release and that a deposit may be required for surgical treatment.

OWNER / OWNER'S AGENT SIGNATURE _____

DRIVER'S LICENSE # _____ STATE _____

PLEASE LIST OTHER FAMILY MEMBERS OR INDIVIDUALS WHO MAY PICK UP YOUR PET (S).
