PATIENT/CLIENT INFORMATION

GLADE SPRING VETERINARY CLINIC

Thank you for giving us the opportunity to care for your pet. To insure the best possible care, please take the time to fill out this form completely. Thank you!!

OWNER REGISTRATION

Owner name: _____ SS# or DL# _____
Spouse /Other name: _____ SS# or DL# _____
Physical Street Address: _____ Mailing address: _____
City: _____ State: _____ Zip code: _____
Home Phone: _____ Cell Phone: _____
Employer: _____ Spouse Employer: _____
Email Address if you would like to receive notifications: _____
In case of an EMERGENCY with my pet please call: _____ at # _____
How did you hear about our clinic: _____

PET INFORMATION

Name of pet being seen today: _____ Birthdate: _____
My pet is a: (please circle) Dog Cat Male/Neutered Female/Spayed
Breed: _____ Color _____
Previous vaccines given and dates: _____
Diet (please list food and treats): _____

Other pets in household:

	NAME:	DOG or CAT	M or F	AGE	VACCINES
1)					
2)					
3)					

PLEASE NOTE: To prevent the spread of infectious diseases to other patients and our staff ALL hospitalized patients must be current on all vaccines and free from internal and external parasites!! If your pet is not current on these vaccines they will be administered while the patient is in our care if they are healthy enough to receive vaccines. Likewise, if your pet has fleas, ticks or intestinal parasites they will receive treatment at owners cost if they are kept in our hospital.

PAYMENT

ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.
Please ask the veterinarian or a staff member if you need an estimate for vaccines, surgery, products or services. In the event of extensive surgical or medical procedures a deposit may be required. We can establish payment arrangements if needed but a plan MUST BE ESTABLISHED and approved before your pet will be discharged!!

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above pet described or any other pet I may present. I assume responsibility for all charges incurred in the care of this patient. I also understand that these charges are to be paid at the time of release.

Signature of Owner: _____ Date: _____

Method of Payment (please circle): Cash Check Credit Card Care Credit