

New Client/Patient Information

The information you provide on this form is confidential and only for the use of PMC & its agents. No information will be given out without written approval by you.

Tell us about you! (Please Print Clearly)

ID Number (for office use only) _____

Your Name _____ Drivers License # _____ Exp. _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ Ext. _____

Cell Phone _____ Other Phone _____

Email Address _____

Would you like to be sent reminders for your pet(s) via this e-mail address? Yes / No

Who else is responsible for your pet?

(Please Print)

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ Ext. _____

Cell Phone _____ Other Phone _____

Email Address _____

How did you hear about us?

- | | |
|--|---|
| <input type="radio"/> Referred by AAHA | <input type="radio"/> Veterinary Practice _____ |
| <input type="radio"/> Yellow Pages Ad | <input type="radio"/> *Individual _____ |
| <input type="radio"/> Pac Bell / Valley Yellow Pages | <input type="radio"/> Hospital Sign |
| (Please Circle One) | <input type="radio"/> Other _____ |

Individual – Please print the name of person who referred you on the line provided

Tell us about your pet!

ID Number (for office use) _____

Pet name _____ Date of Birth _____

Species: Feline / Canine / Other _____ Breed _____

Male / Female Spayed / Neutered / Unaltered Color and Markings _____

Microchip Number _____ Pet Insurance Company _____

Date of last vaccinations _____ Type of vaccination _____

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE RENDERED. PLEASE CHECK YOUR PREFERRED METHOD OF PAYMENT: CASH CHECK CREDIT CARD

CARE CREDIT *For Care Credit, please give us the following information for our records:

Card# _____ - _____ - _____ - _____ Name on Card _____ Limit \$ _____

Signature of owner _____ Date _____

Restraint by Owner When No Ancillary Veterinary Assistance is Available

I _____ understand that the restraint of my animal(s) during examinations and basic treatments offered by the *Pet Medical Center* involve some risk of injuries to myself, my animal(s), agent of mine, and/or the doctor. These injuries can occur from various causes including, but not limited to, bites, kicks, and sudden movements. As an animal owner, I am fully aware of such risks and understand that because of the nature of Pet Medical Center's ambulatory style of veterinary practice, I may or will be required to assist with the restraint of such animal(s).

I am or have been made aware that in some cases my animal(s) may need to be sedated or anesthetized to provide for its, their, the doctor's, my agent's and/or my safety. I have been informed or am aware that while other veterinary practices may provide support staff to restrain or assist in the restraint of animals, such assistance generally is not available with veterinary care provided by Pet Medical Center.

Nevertheless, I hereby request that Pet Medical Center proceed with examinations and appropriate treatments and agree to assume the risks and responsibilities for the occurrence of any injury or other mishap caused by my animal(s) to itself, themselves, or my agents, and/or myself as a result of this decision. In the event my animal(s) has/have shown aggressive behavior toward people or other animals, I agree to advise Pet Medical Center of such behavior before restraint and/or medical care is initiated. I understand that my signature hereunder pertains to all animals owned by me and is not limited to the one or more being examined at the time of this visit.

Signature of Owner or Agent

Date