



WELCOME TO OUR FAMILY!

WE ARE SO GLAD YOU ARE HERE! Thanks for trusting us to give your 4-legged family member high-quality, compassionate care. Please help us meet your needs better by taking a moment to share some important information as we care for your family member today and in the future

**** NOTE: WE WILL NEVER SHARE ANY OF YOUR PERSONAL INFORMATION! ****

PET PARENT NAME: _____			
LAST	FIRST	MIDDLE INITIAL	TITLE (MR., MRS., MS., DR., ETC.)
ADDRESS: _____			
CITY	STATE	ZIP CODE	
HOME PHONE: _____ OK to call? Y / N when?			
(AREA CODE)	NUMBER		
CELL PHONE: _____ OK to call? Y / N when?			
(AREA CODE)	NUMBER		
E-MAIL ADDRESS: (for healthcare reminders only - we will never share any of your personal information or send SPAM)			
HOW DID YOU HEAR ABOUT US?			
EMPLOYER: _____			
WORK PHONE: _____ OK to call? Y / N when?			
(AREA CODE)	NUMBER		
OTHER PET PARENT: _____			
LAST	FIRST	MIDDLE INITIAL	TITLE (MR., MRS., MS., DR., ETC.)
CONTACT PHONE: _____ OK to call? Y / N when?			
(AREA CODE)	NUMBER		
<p>I, the undersigned owner or authorized agent of the pet or pets identified herein, am at least 18 years of age and hereby consent to the examination of my pet by staff veterinarians at Animal Family Practice Veterinary Hospital and, after consultation with me, to prescribe for, treat, hospitalize, anesthetize or perform surgery on my pet. I understand that some risks always exist and that I am encouraged to discuss concerns I have about those risks with my attending veterinarian before treatment is initiated. Should unexpected life-saving emergency care be required, Animal Family Practice Veterinary staff has my permission to provide such treatment and I agree to pay for such care. I understand that an estimate of the costs for services is available upon request and that I am encouraged to discuss all fees attendant to such care before services are rendered and during my pet's admission. I agree to assume financial responsibility for the balance of all services rendered on a cash, credit card, check, or Care Credit basis at the time my pet is discharged from the hospital.</p>			
Signature of owner or agent _____ Date _____			
PLEASE TURN SHEET OVER, THERE'S JUST A LITTLE MORE!			

FOR OFFICE USE ONLY: AVIMARK #: _____
REVIEWED BY: _____ DATE: _____

PLEASE TELL US ABOUT YOUR ANIMAL FAMILY!

Animal Family Members:

	#1	#2	#3	#4	#5
Name:					
Breed:					
Color:					
Male/Female:					
Spayed or Neutered?					
Birthday: (approximate if unknown)					
Date of Last Vaccinations:					
Name of Veterinary Office Administering Vaccinations:					
Medical or other alerts that will help us take the best care of your pet: (bad back, has bitten in the past, hates ears or feet touched, etc)					