



ALL CARING ANIMAL CLINIC

3209 Knickerbocker Road
 San Angelo, Tx 76904
 allcaringanimalclinic.com
 944-9444

Client / Patient Information

Thank you for giving us the opportunity to care for your pet(s). So that we may become better acquainted, please complete the following, **front and back**:

CLIENT INFORMATION

Name: _____ Date of Birth: _____
 Street address: _____ City: _____
 State: _____ Zip: _____ Home Phone: _____
 Work Phone: _____ Cellular Phone: _____
 Your Occupation: _____ Employer: _____
 Driver's License #: _____ Social Security #: _____
 Spouse's Name: _____ Spouse's Date of Birth: _____
 Spouse's Work Phone: _____ Spouse's Cellular Phone: _____
 Spouse's Occupation: _____ Spouse's Employer: _____
 Spouse's DL#: _____ Social Security #: _____
 Your E-mail Address: _____ Spouse's E-mail Address: _____
 Best time to reach you: _____

All fees are due at the time services are rendered.
 Please indicate your method of payment: Cash Check Credit Card

PATIENT INFORMATION

Name: _____ Species: _____ Breed: _____
 Age: _____ Date of Birth: _____ Color: _____
 Sex: Male Female Spayed or Castrated? Yes No

Medical History Give the date that the following vaccinations or procedures were last performed:

<u>Dog</u>		<u>Cat</u>		<u>Ferret</u>	
Rabies vaccination	___/___/___	Rabies vaccination	___/___/___	Rabies vaccination	___/___/___
DHLPP vaccination	___/___/___	FVRCP vaccination	___/___/___	Distemper vaccination	___/___/___
Bordetella vaccination	___/___/___	Feline Leukemia vacc.	___/___/___		
Lyme vaccination	___/___/___	Feline Leukemia test	___/___/___		
Fecal examination	___/___/___	FIV test	___/___/___		
Heartworm test	___/___/___	Fecal examination	___/___/___		
Heartworm preventative	___/___/___	Heartworm test	___/___/___		
		Heartworm preventative	___/___/___		

List any previous surgeries your pet has had: _____
 List any previous or current illnesses: _____
 List any medications your pet is taking: _____
 List any allergies to medications or vaccines: _____
 List any special diets your pet is on: _____
 List any other information that you feel the doctor should know: _____

PLEASE CONTINUE ON THE REVERSE SIDE

HOW DID YOU HEAR ABOUT OUR CLINIC?

- Individual. If so, please give their name so that we may thank them: _____
- Area Wide telephone book
- Verizon telephone book
- Clinic sign
- Web Site
- Standard-Times
- Thrifty Nickel
- Radio advertisement
- Television advertisement
- Another veterinary hospital or clinic. If so, which? _____
- Other, please state _____

RELEASE OF RECORDS

Name of your previous or current veterinarian or veterinary clinic: _____
May we send for your records if necessary? Yes No
If another veterinarian, veterinary clinic, animal control agency, or health department should request medical records from All Caring Animal Clinic concerning your pet(s), may we send them? Yes No

FINANCIAL RESPONSIBILITY / POSSESSORY LEIN

I further understand that I assume financial responsibility for all services rendered. I further agree to pick up my pet at the designated time and to pay in full for all services rendered. I understand that my pet will not be released until the balance is paid in full, and if my pet is not picked up as agreed, a written notice of abandonment will be mailed to me. Twelve days after the notice is issued, my pet will be considered abandoned and may be disposed of in a manner deemed appropriate by All Caring Animal Clinic.

TREATMENT AUTHORIZATION

I understand that every effort will be made to achieve a successful outcome and to provide safe in-hospital care and handling. I hereby authorize this veterinary facility to receive, prescribe for, treat, or perform surgery upon the pet listed on the front side of this form. Furthermore, I agree to pay fees for services rendered at the time the pet is discharged from this facility or service is otherwise terminated. I agree to pay for the reasonable costs of collection in the event that collection efforts become necessary. I understand that veterinary service is provided during nighttime hours only as necessary in the judgment of the veterinarian in charge. Continuous presence of qualified personnel during nighttime hours may not be provided.

TO HELP PREVENT THE SPREAD OF INFECTIOUS DISEASES, ALL HOSPITALIZED, BOARDING, AND DROP-OFF ANIMALS MUST BE CURRENT ON ALL VACCINATIONS.

BY SIGNING THIS DOCUMENT, I ATTEST THAT I HAVE READ AND AGREE TO THE AFOREMENTIONED CONDITIONS.

Signature of owner or responsible person

Date