ST. ROSE ANIMAL HOSPITAL + UrgentCare™

PET CHECK-IN FORM

PET OWNER INFORMATION:

Last Name: _____ First Name: _____

Driver's License: _____ Social Security #: _____

Email Address: _____ Home Phone: _____ Cell Phone: _____

Street Address: _____ Appt. # _____

City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Can we send you message reminders to your cell phone? ◯ Yes ◯ No

SPOUSE INFORMATION

Spouse's Name: _____

Spouse's Employer: _____ Work Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

YOUR PETS

Please list your pets below and include vaccine expiration dates with proof of vaccination from your veterinarian.

(Note: AROAP please highlight due vaccines)

Pet 1

Name: _____ Breed: _____ Species: _____

Age: _____ Weight: _____ Sex: ◯ Male ◯ Female Spayed/ Neutered: ◯ Yes ◯ No

Da2pp: _____ Bordetella: _____ Rabies: _____ Fecal: _____ Deworming: _____

Pet 2

Name: _____ Breed: _____ Species: _____

Age: _____ Weight: _____ Sex: ◯ Male ◯ Female Spayed/ Neutered: ◯ Yes ◯ No

Da2pp: _____ Bordetella: _____ Rabies: _____ Fecal: _____ Deworming: _____

Pet 3

Name: _____ Breed: _____ Species: _____

Age: _____ Weight: _____ Sex: ◯ Male ◯ Female Spayed/ Neutered: ◯ Yes ◯ No

Da2pp: _____ Bordetella: _____ Rabies: _____ Fecal: _____ Deworming: _____

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PET CHECK-IN FORM

VACCINES FOR CATS

FVRCP: _____ Rabies: _____ FELV / FIV: _____ FELV / FIV Test: _____ Fecal: _____ Deworming: _____

How did you first learn about us?

◯ Internet ◯ Magazine ◯ Mail ◯ Friend Referral: _____

◯ Veterinarian Referral: _____ ◯ Other: _____

PREFERRED METHOD OF PAYMENT

◯ Cash ◯ Credit Card

Credit Card Number: _____

Type of Card: _____ Expiration Date: _____ CV2: _____

◯ *I, _____ , allow St. Rose Animal Hospital + Urgent Care to charge this card for my pets medical care. By checking this box, I am acknowledging that I understand that fees are to be paid at the time services are rendered.*

AUTHORIZATION FOR PROFESSIONAL SERVICES

I hereby authorize St. Rose Animal Hospital + Urgent Care to perform such diagnostic, therapeutic and surgical procedures as are necessary and advisable for treatment and maintenance of my pet's health and well being.

The nature of such services has been described to me to my satisfaction, and while I expect all procedures to be done to the best abilities of the professional staff, I realize that no guarantee or warranty can ethically or professionally be made regarding the results or cure. I agree to pay all charges incurred at the time of release of my pet, including reasonable attorney's fees and cost of collection in the event of default. I further understand that if payment becomes 30 days past due, delinquency charges at the lesser of the annual rate of 18%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due.

I also authorize the hospital director and his/her staff to provide veterinary services as requested or in emergency circumstances to follow through with such procedures as are necessary for the well being of my pet on a continuing basis until further advised in writing.

Signature: _____ Date: _____