West Palm Animal Clinic

EMAIL: Office@WestPalmAnimal.com **WEBSITE:** www.WestPalmAnimal.com

FACEBOOK: www.facebook.com/WestPalmAnimalClinic

DAYS OPENED: MON., TUES., WED., THURS., FRI | HOURS : 7 AM - 6 PM

Thank you for the opportunity to care for your pet!

Please take a moment to complete this information sheet for the creation of your pet's hospital records.

OWNER'S INFORMATION

Owners Name: _____ Spouse/Other: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____

DISCOUNT: ☐ 10% Active Military / Veteran / Law Enforcement Discount (or) ☐ 10% Senior Citizens Discount (Over age 60)

ANIMAL MEDICAL HISTORY

☐ Cat ☐ Dog DOB/Age: _____

Name: _____

Breed: _____ Color: _____

☐ Male ☐ Female

☐ Neutered/Spayed

Last Day of Vaccines? _____

Is your pet on heartworm prevention? ☐ Yes ☐ No

If Yes, what kind? _____

Is your pet using flea prevention? ☐ Yes ☐ No

If Yes, what kind? _____

How did you first hear about us?

☐ Angie's List

☐ Internet Search

- ☐ Our **Website**: www.WestPalmAnimal.com
- ☐ Our **Facebook** Page: www.facebook.com/WestPalmAnimalClinic
- ☐ **Yellow Page** (www.YP.com)
- ☐ **YELP**

☐ Hospital Sign / Drive-by

☐ Referred by (friend/other): _____

☐ Referring Veterinarian: _____

☐ Other: _____

- I request that the doctors and staff at West Palm Animal Clinic perform the services which are necessary to the examination and medical treatment of the animal(s) presented by me. I am the owner or agent for the described animal(s) and have authority to execute this consent.
- I authorize the veterinarian on duty (and assistant they may designate) to examine the animal(s) and to administer the examination findings. I therefore, hereby consent to and authorize the performance of such procedures as deemed necessary and desirable in the veterinarian's professional judgment.
- I understand that the treatment of the patient(s) will be conducted with due care and in accordance with the prevailing standards of care in veterinary medicine. I certify that no guarantee or assurance has been made as to the results that may be obtained through the course of treatment undertaken by the provider.
- I agree to pay all attorney's fees, finance charges, collection cost and other cost of litigation incurred in the collection of past accounts.
- I understand that a written estimate for charges will be provided at my request. I also consent to the release of medical information.
- I assume the responsibility for all charges incurred to the patient for services rendered and understand that full payment is required upon request.

Signature of Owner or Responsible Agent: _____ Date: _____

PROFESSIONAL FEES ARE DUE WHEN SURRENDERED

2254 N. Military Trail, West Palm Beach, Florida, 33409 | Office Tel: (561) 686-6033