Advanced Veterinary Care Center AVCC

Compassionate Care • Compassionate People

INFORMATION FORM

DATE ____/____/____

OWNER(S) NAME _____
LAST FIRST M.I.

SPOUSE/OTHER _____

HOME ADDRESS _____
STREET APT# CITY ZIP

HOME PHONE _____ CELL PHONE _____

E-MAIL ADDRESS _____

EMPLOYER _____ WORK PHONE _____

REFERRING VETERINARIAN _____ PHONE _____

HOSPITAL NAME _____

OTHER REFERRAL SOURCE _____

PRIMARY VETERINARIAN _____ PHONE _____

HOSPITAL NAME _____

PET NAME _____ D.O.B. _____ BREED _____

SEX _____ SPAY/NEUTERED Y☐ N☐ COLOR _____

IS YOUR PET CURRENT ON VACCINATIONS Y☐ N☐

DOES YOUR PET EXHIBIT ANY BEHAVIORAL PROBLEMS THAT MAY POSE A RISK TO OUR DOCTORS OR TECHNICAL STAFF? Y☐ N☐ IF YES, PLEASE EXPLAIN: _____

_____

DRIVERS LICENSE NO. _____ EXPIRES _____ STATE _____

I WOULD LIKE MY PET'S RECORDS FAXED TO:
(Check all that apply)

PRIMARY VETERINARIAN☐ REFERRING VETERINARIAN ☐

OTHER _____ ☐

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED. I AGREE IN THE EVENT OF NON-PAYMENT TO BEAR THE COSTS OF FINANCE CHARGES AT THE RATE OF 1% PER MONTH, THE COSTS OF ALL COLLECTION AND/OR COURT COSTS AND LEGAL FEES, SHOULD THIS BE REQUIRED.

SIGNATURE OF RESPONSIBLE OWNER
OR AGENT (18 YEARS OR OLDER) _____