WELCOME TO
ASSOCIATED VETERINARY CLINIC

Please provide us with the following information about yourself and your pet:

YOUR NAME_____

PLEASE LIST **ALL PERSONS** AUTHORIZED TO REQUEST SERVICES FOR THIS PET:

_____

ADDRESS:_____

CITY/STATE/ZIP CODE_____

HOME PHONE NUMBER_____

CELL PHONE NUMBER_____

EMAIL ADDRESS_____

PLACE OF EMPLOYMENT AND PHONE_____

NAME OF PET BEING SEEN TODAY_____

CANINE **FELINE** **OTHER(**please indicate)_____

BREED_____ **COLOR**_____

SEX: **FEMALE** **MALE** **IS THE PET SPAYED OR NEUTERED?**_____

PET'S BIRTHDATE (if known, if not, guess)_____

Do you currently own any other pets? (Please list)_____

How did you hear about our clinic? (phone book, ad, road sign, friend, etc.)_____

Wisconsin Law requires written informed consent to release your pet's health care records to certain third-party/non-owners (Wis. Stat. 453.075**). Please indicate to whom you authorize release of your records to:**

☐ Other veterinary clinics/hospitals
☐ Kennels/groomers/pet daycare
☐ Pet Insurance Companies
☐ Rescue/Humane society organizations
☐ Property Management Companies
☐ Other:_____

Payment is needed at the time of service. How will you be settling your account today?
Cash_____ Check_____ Credit card_____

I understand there will be interest of 1% per month on all unpaid balances. Failure to make a payment within 30 days of services will lead to the account being turned over to our collection agency and a termination of all veterinary services from our clinic.

Client Signature: _____ Date_____