

**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 _____

PHONE NUMBER #1 _____ **THIS NUMBER BELONGS TO:** _____

PHONE NUMBER #2 _____ **THIS NUMBER BELONGS TO:** _____

PHONE NUMBER TO RECEIVE TEXT REMINDERS ON _____

EMAIL ADDRESS FOR RECEIVING EMAIL REMINDERS _____

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) _____

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:**

- | | |
|---|--|
| <input type="checkbox"/> Other veterinary clinics/hospitals | <input type="checkbox"/> Rescue/Humane society organizations |
| <input type="checkbox"/> Kennels/groomers/pet daycare | <input type="checkbox"/> Property Management Companies |
| <input type="checkbox"/> Pet Insurance Companies | <input type="checkbox"/> 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 _____