Date_____

Owner's Name_____
Spouse's Name_____
Are there any other authorized persons to approve treatment for your pet(s) on your behalf? _____
Street Address_____
Mailing Address_____
City_____ Zip Code_____
Home Phone #_____ Cell Phone #_____
Work Phone #_____ Spouse's Work #_____
Spouse's Cell Phone #_____
Driver's License #_____ State_____
Email Address_____
How did you hear about us? _____

Pet's Description

Name_____ Dog ( ) Cat ( ) Other_____
Breed_____ Color_____
Male ( ) Neutered Male ( ) Female ( ) Spayed Female ( )
Date of Birth/Age_____

Medical History

Previous Veterinarian_____
Date of last vaccinations_____
Is your dog currently on heartworm prevention? Yes ( ) No ( )
If yes, what type? _____
Briefly describe past medical problems_____
_____

Financial Information

We accept cash, check, Master Card, Visa, Discover, and Care Credit as forms of payment. Professional fees are to be paid at the time services are rendered unless other arrangements have been made in advance. An estimate of fees will be given if requested. I herby authorize the doctors and staff of Round Rock Animal Hospital to administer such treatment, diagnostic, surgical, and anesthetic procedures as they deem necessary. I realize that no guarantee can be made regarding the results of these procedures. Further, I agree to assume full financial responsibility for these procedures.

_____
Owner/Agent Signature

In the event of failure to comply with the terms of this agreement, the account will be placed with our collection agency and you will be charged a monthly 1% collection fee. All returned checks are subject to a $25.00 fee.

Office Use
Receptionist's Initials: