WELCOME FORM

Thank you for giving us the opportunity to care for your pet. We will be happy to answer any questions you have about your pet's health. To ensure the best care possible, please take the time to fill out the form completely. Thank you!

Date_____

Owner_____ Spouse _____
Driver's License Number _____ Date of Birth _____
Address_____
City _____State_____Zip_____
Please place a check by the best number to reach you at:
☐ Home Phone (___)_____ ☐ Work Phone (___)_____ ☐ Cell Phone (___)_____
Email Address _____
Emergency Contact Name_____ Phone_____
How did you learn of our clinic? ☐ Yellow Pages ☐ Recommendation ☐ Other _____
If recommended, by whom? _____
Number of pets: Dogs _____ Cats _____ Other (specify) _____
Reminder Preference (you may check more than one) ☐ Card ☐ E-Mail ☐ Text

PET HEALTH HISTORY

New Pet's Name: _____ ☐ Dog ☐ Cat ☐ Other _____
Breed: _____ Date of Birth: _____
Color: _____ Sex: ☐ Male ☐ Neutered Male / ☐ Female ☐ Spayed Female
Vaccination History (date and type of last vaccinations): _____
_____
What kind of food do you feed your pet? _____
What medications is your pet on? _____

New Pet's Name: _____ ☐ Dog ☐ Cat ☐ Other _____
Breed: _____ Date of Birth: _____
Color: _____ Sex: ☐ Male ☐ Neutered Male / ☐ Female ☐ Spayed Female
Vaccination History (date and type of last vaccinations): _____
_____
What kind of food do you feed your pet? _____
What medications is your pet on? _____

Please provide your previous veterinarians contact information so we can have your pet's medical records faxed to us:
Name: _____ Phone: (_____) _____ - _____

Please circle any symptoms or problems that you have noticed with your pet:

Patient Number 1:			Patient Number 2:		
☐ Behavior Problems	☐ Lack of Appetite	☐ Sneezing	☐ Behavior Problems	☐ Lack of Appetite	☐ Sneezing
☐ Bleeding Gums	☐ Limping	☐ Thirst and/or	☐ Bleeding Gums	☐ Limping	☐ Thirst and/or
☐ Breathing Problems	☐ Loss of Balance	Urination Increased	☐ Breathing Problems	☐ Loss of Balance	Urination Increased
☐ Coughing	☐ Scooting	☐ Vomiting	☐ Coughing	☐ Scooting	☐ Vomiting
☐ Diarrhea	☐ Scratching	☐ Weakness	☐ Diarrhea	☐ Scratching	☐ Weakness
☐ Eyes Bulging/ Bloodshot	☐ Shaking Head ☐ Depressed/	☐ Urination or Bowel Problems	☐ Eyes Bulging/ Bloodshot	☐ Shaking Head ☐ Depressed/	☐ Urination or Bowel Problems
☐ Ear Problems	☐ Gagging	☐ Lethargic	☐ Ear Problems	☐ Gagging	☐ Lethargic
☐ Other _____			☐ Other _____		

TURN OVER

Cancelled Appointments and No Show Policy

I understand that there will be a $25.00 fee for appointments NOT cancelled within 24 hours and no-show appointments.

*** Client Initials: _____ Date: _____**

Payment Policy

Our office DOES NOT offer billing. Payment is due ON the day of service. We will gladly prepare a written estimate for your appointment if you desire. Occasionally, a deposit may be required for certain procedures. We accept the following forms of payment: Cash, Personal Check, Visa, MasterCard, Discover, American Express, & Care Credit.

**Please note that there is a $35.00 fee for a returned check in addition to the fees your bank may charge.*

*** Client Initials: _____ Date: _____**

Medical Inquiry & Release Authorization

I give permission for the doctors and staff of Countryside Veterinary Clinic to release or inquire about necessary medical information and vaccination status concerning my pet from other animal care professionals such as other veterinary hospitals, animal control, boarding facilities, grooming facilities, rescue or shelter organizations or other related animal care professionals. Current vaccination status may also be obtained from us by the health department or landlord.

*** Client Initials: _____ Date: _____**

Media Release Authorization

With your permission, we occasionally post images and videos of our patients, patients with our staff, and patients with their people on our social media sites and/or our website. We would like your permission to share photos or videos from your pets' visits with us on these sites.

☐ I approve the use of all photos/videos of my pet(s), myself with my pet(s), and my pet(s) with the Countryside Veterinary staff for display on the Countryside Veterinary website and/or social media sites.

☐ I approve the use of photos/videos of my pet(s) and Countryside Veterinary staff only (no images of the client or family members will be taken) for display on the Countryside Veterinary website and/or social media sites.

☐ I do not approve the use of photos/videos of my pet(s) for display on the Countryside Veterinary website and/or social media sites.

*** Client Initials: _____ Date: _____**

Treatment/Payment Authorization

I am the owner/authorized agent for the animal named above, and I am 18 years of age or older. I give permission for the doctors and staff of Countryside Veterinary Clinic to examine and treat my pet as I have requested. I understand that medical therapy of any kind involves some risk to my pet, including but not limited to adverse drug reactions, and agree to hold the hospital and its employees harmless in the absence of negligence, in connection with these procedures. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained. In the event of an emergency I understand that life saving measures will be initiated while an attempt is made to contact me. If I cannot be contacted at the listed numbers, the doctors and staff are directed to make decisions deemed best for my pet. I understand that payment is due when services are rendered, and I agree to pay for those services rendered. I understand that interest will accrue on any balance outstanding over 30 days at 1.5% per month will be assessed on each monthly statement. I agree to pay for these and any additional cost incurred by the hospital in the collection of any outstanding debt for services rendered.

Signature _____ Date _____

TURN OVER