



Thank you for giving us the opportunity to care for your pet. Please help us better meet your needs by taking a few moments to fill out this information sheet.

Your Name: _____

Spouse/Other: _____

Address: _____

Cell # _____

City: _____ State: ____ Zip: _____

Work Phone # _____

Home Phone # _____

Cell Phone # _____

Emergency Contact Person: _____

Work Phone # _____

Phone: _____

(Please place an X next to the number which we should use as the primary phone number)

E-Mail Address _____ I would like to receive reminders and specials via e-mail

How or by who were you referred to our practice? _____

Professional fees are due at the time services are rendered.
We will gladly prepare an estimate prior to services if you so desire. Please ask a receptionist or doctor.
In order to accept your checks we must have a current copy of your New Mexico Driver's License.

Your Preferred Method of Payment: () Cash () Check () Credit Card

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) listed and additional pets I present. Furthermore, I agree to pay fees for the services rendered at the time the pet is discharged from the hospital or the service is otherwise terminated. I agree to pay for the reasonable costs of collection in the event that collection efforts become necessary. I understand that a service fee of \$25.00 will be assessed for each non-sufficient funds check and/or certified letter that must be sent.

Signature: _____ Date: _____

To help prevent the spread of infectious diseases, ALL hospitalized and boarded animals must be current on all vaccinations. DUE TO STATE LAW AND INSURANCE REQUIREMENTS, ALL DOGS & CATS MUST BE CURRENT ON RABIES VACCINATION. Vaccination can be updated at the time of your appointment.

Pet Name: _____ DOB _____

Dog ___ Cat ___ Other _____

Breed: _____ Color _____

Sex: Female ___ Spayed ___ or Male ___ Neutered ___

Medication Alert. Please list medications your pet has an Allergic or Adverse reaction to: _____

Please List Current Health Concerns/Diseases/Chronic Conditions you wish to discuss: _____

Additional Pet(s) Information:

Pet Name: _____ DOB _____

Dog___ Cat___ Other _____

Breed: _____ Color _____

Sex: Female ___ Spayed ___ or Male ___ Neutered ___

Medication Alert. Please list medications your pet has an Allergic or Adverse reaction to: _____

Please List Current Health Concerns/Diseases/Chronic Conditions you wish to discuss:

Pet Name: _____ DOB _____

Dog___ Cat___ Other _____

Breed: _____ Color _____

Sex: Female ___ Spayed ___ or Male ___ Neutered ___

Medication Alert. Please list medications your pet has an Allergic or Adverse reaction to: _____

Please List Current Health Concerns/Diseases/Chronic Conditions you wish to discuss:

Pet Name: _____ DOB _____

Dog___ Cat___ Other _____

Breed: _____ Color _____

Sex: Female ___ Spayed ___ or Male ___ Neutered ___

Medication Alert. Please list medications your pet has an Allergic or Adverse reaction to: _____

Please List Current Health Concerns/Diseases/Chronic Conditions you wish to discuss: