Inland Northwest
Veterinary Specialty Care
Internal Medicine

Client/Patient Information

Please print clearly and fill out as much information as possible

Owner Name_____ **Spouse/Other**_____

Address_____

City_____ **State**_____ **Zip Code**_____

Home Phone # ( )_____ **Cell Phone #** ( )_____

Work Phone # ( )_____ *Please indicate the number where you can best be reached

e-mail address_____

Employer's Name _____

Emergency Contact Name and Phone # _____
(Someone other than yourself who can make decisions about your pet's care in the event that you cannot be reached)

Name of Your Regular Veterinary Clinic _____
(Where we will fax records for your pet's follow-up care)

Pet Name_____ **Breed** _____ **Age**_____

Color_____ **Male / Neutered | Female/ Spayed**

By signing this form:

- I understand that **payment is required in full at the time of service** for all services rendered and I accept full financial responsibility. There is no billing available through this office. **INITIAL**_____
- I give permission for the records to be faxed to the above veterinary clinic or to any veterinarian requesting records to facilitate continued treatment. **INITIAL**_____
- I confirm that I am the legal owner of the above animal(s) and/or am authorized to make medical decisions regarding said animals. **INITIAL**_____

Signature _____ **Date**_____