

# 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 \_\_\_\_\_