VINEYARD VETERINARY HOSPITAL
QUALITY CARE FOR DOGS AND CATS

Welcome

Client Information

Last Name: _____ First Name:_____ Spouse/Partner:_____

Address: _____ City/State/Zip: _____

Home Phone: (___)_____ Cell Phone: (___)_____ E-mail: _____

Owner DOB: _____ (*Owner DOB is required by **DEA** for any Controlled Medication dispensed for pet*)

Driver's License and state of issuance:_____

Employer:_____ Work Ph: (___)_____

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Phone Number: (___)_____

Referred By:

Verizon Yellow Pages ◯ ***Community LittleBook*** ◯ ***Hospital Sign*** ◯ ***Internet*** ◯

Recommended By:_____

(Client – Veterinarian – Rescue Group ~ Please let us know so we can Thank them!)

Please Sign The Following Authorization For Treatment:

I hereby authorize the staff of Vineyard Veterinary Hospital to render any treatment that is deemed necessary to my pet(s) health while in custody of the hospital. I understand that in the event of any unusual or emergency circumstances, the staff will make every attempt to contact me or my designated representative before, if time permits, proceeding with treatment. I understand that I will be financially responsible for all emergency procedures including the Estimate of Charges provided to me in person or over the telephone. ***I understand that professional fees are to be paid at the time services are rendered and a deposit is required on all pets admitted to the hospital.***

_____ _____

Signature of Owner **Date**

Method of Payment:

Visa ◯ ***MasterCard*** ◯ ***American Express*** ◯ ***Discover*** ◯ ***Care Credit*** ◯ ***Cash*** ◯ ***Personal Check*** ◯*

Photo I.D. is required on all Credit Card and/or Personal Check payments.