

FIRST NAME _____ LAST NAME _____

CO-
OWNER/AGENT _____ PHONE _____

STREET ADDRESS _____

CITY _____ ZIP PLUS 4 _____

HOME PHONE INCLUDING AREA CODE _____

DAY OR CELL PHONE _____ FAX _____

E-MAIL _____

BEST TIME TO REACH YOU: MORNING AFTERNOON EVENING ANY

HOW DID YOU FIND US: _____

PHARMACY _____ PHONE _____

MAY WE CONTACT YOUR VETERINARIAN FOR PREVIOUS RECORDS? Y N

NAME: _____ PHONE _____

I UNDERSTAND THAT ANIMALS CAN BE UNPREDICTABLE, THEREFORE I
ASSUME FULL RESPONSIBILITY FOR ANY DAMAGE DONE AT ANY TIME BY
MY PETS TO MY FAMILY OR PROPERTY. Y N

I FURTHER AGREE TO COOPERATE WITH DR. OSWALT OR ANY OF HER
ASSISTANTS WITH WHATEVE RESTRAINTS SHE DEEMS NECESSARY AS
PART OF THE EXAMINATION OR TREATMENT OF MY PET(S) Y N

I ATTEST THAT I AM THE OWNER/AGENT AND HAVE THE AUTHORITY TO
MAKE MEDICAL DECISIONS FOR THE PETS LISTED ON THE BACK OF THIS
FORM. I ALSO AGREE TO BE RESPONSIBLE FOR THE EXPENSES SO
INCURRED. Y N

PAYMENT: CASH CHECK

Cancellation Policy: If you are unable to keep your scheduled appointment, please give
our office 24 hours notice or you may be billed for the missed call.

Owner/Agent's Signature: _____ DATE: _____

PET'S NAME				
BREED				
COLOR				
BIRTHDATE				
SEX				
NEUTERED				
DATE OF LAST VACCINATION				
DISTEMPER				
RABIES				
OTHER				
CURRENT MEDICATIONS				
CONTINUING MEDICAL PROBLEMS				
DIET(NAME)				
DRY				
CANNED				
OTHER				
GROOMING:				
NEVER/RARELY				
COMB/BRUSH				
BATHE				
PROFESSIONAL				
INDOOR				
OUTDOOR				
PET DOOR				
TRAVELS OUT OF W. WASH				