INFORMATION ABOUT YOUR PET (PLEASE PRINT)

PET'S NAME_____ BREED_____ COLOR_____

BIRTHDATE or AGE_____ SEX: MALE ☐ or FEMALE ☐ NEUTERED or SPAYED ☐

MEDICAL HISTORY (Please check the box(es) that apply to your pet.)

CANINE:			FELINE:		
☐	Distemper Vaccine	When_____	☐	Distemper Vaccine	When_____
☐	Bordetella/Kennel Cough	When_____	☐	Feline Leukemia	When_____
☐	Rabies Vaccine	When_____	☐	Rabies Vaccine	When_____
☐	Heartworm Check	When_____	☐	Felv/FIV Combo	When_____
☐	Fecal Exam	When_____	☐	Fecal Exam	When_____

Name of Veterinary Clinic vaccines were last done:_____

Reason for today's visit:_____

List any previous problems that we should know about (i.e., Surgery):_____

List any know drug allergies:_____ Special diet?_____

INFORMATION ABOUT YOU (Please print)

OWNER(S) Mr. Mrs. Dr. Ms. _____ SPOUSE/OTHER_____
Last First Middle Initial First

Address _____
Street City State Zip Code

E-mail address:_____ Home Phone: _____

Cell Phone: _____ Spouse/Other Cell Phone: _____

Place of employment_____ Work Phone Number_____

Spouse/Other Place of Employment_____ Work Phone Number_____

If we need to contact you, what number would be best to call?_____ When?_____

How did you become aware of our clinic? ☐ Yellow Pages ☐ Clinic Sign ☐ Other_____

ALL FEES ARE DUE UPON RELEASE OF PATIENT

We accept Cash, Check, Visa, MasterCard, Discover, and American Express.

Any time in-hospital treatment, emergency care, surgery or hospitalization are provided A DEPOSIT PRIOR TO TREATMENT MAY BE REQUIRED. A written estimate of fees will be provided upon request prior to in-hospital treatment, emergency care, surgery or hospitalization. Payment for services is due upon completion of care to your pet.

Any accounts unpaid for thirty (30) days will be subject to late charge penalty of 1.5% per month ($2.00 minimum) on the unpaid balance.

Failure to make payment satisfactorily after care has been rendered to your pet is a basis for legal action against you for collection purposes. The person authorizing treatment agrees to pay all court costs, reasonable attorney fees, and hereby waives all rights of exemption under the laws of the State of Alabama.

This transaction constitutes the entire agreement between the person authorizing care and Doctor Kelly Baumann, owner of Trussville Animal Hospital, P.C.

Person authorizing treatment_____
SIGNATURE OF PERSON AUTHORIZING TREATMENT

Driver's License Number:_____ DATE_____