



WELCOME! Our staff is dedicated to personalized quality medicine and individualized pet care. To help us serve you better, please provide us with the following information.

Must be 18 years or older.

Client Information

Name: _____

Spouse's Name(optional): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone 1: _____ **Home/Cell/Work(CircleOne)**

Telephone 2: _____ **Home/Cell/Work/Spouse(CircleOne)**

Email: _____

Your date of birth: _____ / _____ / _____
MM DD YYYY

Pet(s) Information

1. Name: _____ Male[] Neutered[] ---- Female[] Spayed[]

- a. Your Pet's Date of Birth: _____
- b. Species: Canine(Dog)[] Feline(Cat)[] Other[] _____
- c. Breed: _____
- d. Color: _____

2. Name: _____ Male[] Neutered[] ---- Female[] Spayed[]

- a. Your Pet's Date of Birth: _____
- b. Species: Canine(Dog)[] Feline(Cat)[] Other[] _____
- c. Breed: _____
- d. Color: _____

Previous Veterinary Hospital(s):

1) **Veterinary Hospital Name:** _____

Information to be released includes:

[] Entire Medical Records -- includes full medical history, original lab results, radiographs and vaccination history.

[] Vaccination History -- includes past and current vaccinations.

2) **Veterinary Hospital Name:** _____

Information to be released includes:

[] Entire Medical Records -- includes full medical history, original lab results, radiographs and vaccination history.

[] Vaccination History -- includes past and current vaccinations.

3) **No Previous Veterinary Hospital** []



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- ★ **I understand that vaccination reactions, unforeseen medical and surgical complications may occur and require treatment and/or hospitalizations which could be at additional expense beyond estimated costs.**
- ★ **Payment is due in full at time of service and a deposit may be required if surgery or hospitalization is necessary. I agree to pay all fees in full at the time of services are rendered and accept full responsibility for this/these animal(s). We accept cash, personal checks, VISA, Mastercard, Discover, American Express and Care Credit.**
- ★ **I hereby authorize the release of my pet(s) medical records from the above veterinary hospital. They are to be sent to Napa West Pet Hospital.**

Would you like to leave a credit card on file today? If yes, please circle below:

Visa

Mastercard

AmEx

Discover

CareCredit

Card number:

Expiration date:

CVC:

Owner's Signature: _____ Date: _____