



# Welcome



*Specialist Referral  
Patricia Kupanoff, DVM  
Diplomate, American College of Veterinary Surgery, SA*

**Thank you for visiting us!**

Owner's Name		Spouse/Other	
Home Street Address		City	State ZIP
Primary Phone	Alternate Phone	Cell Phone	Employer

Pet's Name		Species (Dog, Cat, etc.)	Breed
Birthdays or Age	Sex	Spayed/Neutered	

Vaccination Dates: Rabies: \_\_\_\_\_ Distemper group: \_\_\_\_\_ Other: \_\_\_\_\_

Current Medications/Vitamins/Supplements: \_\_\_\_\_

Food type and amount: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

<p><b>Who is your regular veterinarian (name AND location):</b> _____</p> <p><b>Were you referred to us by your regular veterinarian (please circle)      YES      NO</b></p> <p><b><i>How did your hear about our hospital?</i></b></p> <p><input type="checkbox"/> Friend (Who may we thank for referring you) _____</p> <p><input type="checkbox"/> Yellow pages    <input type="checkbox"/> Hospital sign    <input type="checkbox"/> Website    <input type="checkbox"/> Magnet from yellow pages</p> <p><input type="checkbox"/> Magnet from Veterinarian    <input type="checkbox"/> Other (please specify) _____</p>
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## OFFICE FINANCIAL POLICY

*Payment in full is due at the time your pet is discharged from FIRST Regional Animal Hospital. At your request, we will provide a written estimate of charges for the care of your pet.*

I authorize the doctors to perform treatment for my pet. I assume responsibility for all charges incurred in the care of this animal. If my pet requires admission to the hospital, I understand that a deposit is required. I also understand emergency veterinary care is not intended to be a substitute for complete veterinary care.

Method of Payment:

Cash     debit     check     Visa/MasterCard     Discover     American Express     Care Credit

OWNER/AGENT Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Expiration: \_\_\_\_\_ Date of Birth: \_\_\_\_\_