



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
Birthdate 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>Who is your regular veterinarian (name AND location): _____</p> <p>Were you referred to us by your regular veterinarian (please circle) YES NO</p> <p><i>How did your hear about our hospital?</i></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: _____