Compassionate Care
VETERINARY CLINIC

Client Information

Owner's Name: _____

Spouse / Co-Owner: _____

Driver's License # (if paying by check): _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Mobile Phone: _____

Spouse/Other/Work Phone: _____ _____

Email Address: _____

How would you prefer we communicate with you about your pet? Phone / Email / Text

In case of EMERGENCY, please call: _____ Phone #: _____

How did you hear about us? Previous Client □ Facebook □ Clinic Sign □ Newspaper □ Internet □
Friend/Family □ Referred by: (so we can thank them!):_____

Payment Information

We are happy to provide an estimated cost for treatment plans upon request. **All professional fees are due at the time services are rendered.** Compassionate Care Veterinary Clinic accepts: Cash, Personal Checks (providing DL#), Visa/MasterCard, American Express, Discover Card or CareCredit for payment.

To prevent the spread of infectious diseases and parasites; hospitalized patients and pets in the clinic for boarding or grooming must be current on all vaccines and free of internal and external parasites. I authorize the doctor to provide vaccines and parasite control as needed for my pet.

I authorize Compassionate Care Veterinary Clinic to photograph my pet for marketing purposes and publish those photos in any form.

Thank you for allowing us to care for your pet! Please feel free to contact us at 319-483-5049 oremail us at CompassionateCareWaverly@gmail.com with any questions or to schedule /reschedule your pet's appointment.

Signature of Client Responsible for Pet(s): _____

Date: _____

Patient Medical Information

	PET #1	PET #2	PET #3
Name:			
Species (cat, dog, other):			
Breed:			
Color:			
Male or Female:			
Spayed/Neutered	Yes___No___	Yes___No___	Yes___No___
Chronic Health Concerns:			
Current Medication(s):			
Diet (What type & amount of food):			
Previous Animal Medical History: Clinic Name or DVM Name & Phone number if known:			

Comments: _____
_____
_____
_____
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