



Owner's Name: _____ Spouse/Other: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Primary/Cell _____ Secondary Phone: _____ Employer Name: _____

***Email address: _____

**We use peanut butter and other various treats for positive reinforcement during visits. Does anyone in your home have food allergies that we should be aware of? Please list them here:* _____

****We use a communication software called PetDesk to manage client communications, send you reminders about upcoming appointments and to send you offers about our products and services. You agree that we may share your name, pet's name, email address, address and phone number with PetDesk to facilitate this process.

You will receive a welcome email within 24 hours. You may elect to OPT out of any reminders services at that time.

How do you prefer us to contact you regarding your pet (s)' health?

- Call Primary/Cell
- Text Primary/Cell
- Email

How did you hear about our clinic?

- Word of Mouth: Is there an Individual we may thank?** _____
- Internet: Which site?** _____
- Humane Society or Rescue Organization: Name of facility** _____
- Location of clinic**
- Previously/Current client**
- Other:** _____

Pet's Name _____ Species: ___ Canine ___ Feline

Breed: _____ Color/Description: _____

Date of Birth: _____ Sex: _____ Spayed/Neutered? Yes or No

Microchip/Tattoo ID number: _____

Did you bring records today from your previous veterinarian? Yes or No. If no, who can we contact? _____

***Picture Release: I understand and approve that Anderson Lakes Animal Hospital may take pictures during the course of my visit for use on their website and/or social media.**

Anderson Lakes Animal Hospital may use pictures of clients/patients for promotional and publicity purposes without liability or obligations to the participants.

___ please opt me out of picture participation

We gladly prepare a written treatment plan with fees associated with the doctors plans for care.

Please ask the Technician/Receptionist or Doctor to provide a plan before treatments.

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

By signing below I agree to the above terms and conditions.

Signature: _____

We accept cash, check*, Visa, Mastercard, Discover or Care Credit.

**A \$25.00 fee will be levied for any check that is returned due to insufficient funds or for any other reason. An alternative payment method to satisfy the account balance and this fee will be required immediately.*