

Have we previously seen this pet? Y N When? _____ Have you had other pets treated here? Y N When? _____

Please Print:

Provide Full Legal Name (No Abbreviations or Nicknames)

Owner's Name: _____
Last First Middle

Email Address: _____

Present Address: _____
Street Number City State Zip

Permanent Address: _____
Street Number City State Zip

Telephone Numbers: () _____ () _____ () _____
Home Business Cell/Other (specify)

Owner's Place of Employment: _____
Name of Business City State Zip

Husband/Wife Full Name: _____

Are you an AU student? Y N **Student ID#** _____ **School/College Enrolled:** _____

Pet Information

Species: Dog _____ Cat _____ Other (specify) _____ **Breed:** _____
Indicate Miniature or Toy of Breed if Applicable

Sex: _____ **Date of Birth:** _____ **Color:** _____
Indicate Spayed/Castrated if Applicable

Animal's Name: _____
Include Registered Name and Call Name, If Applicable

Presenting Concern or Service(s) Requested: _____

Referral Information

Referring Veterinarian: _____ **Clinic Name:** _____

Address: _____ **Clinic Number:** () _____
Street and Number City St Zip

The referring veterinarian listed above will receive a report of our clinician's findings and recommendations. If the referring veterinarian is not your pet's primary care veterinarian, would you like for them to receive a report? Y N If yes, provide their name and address.

Primary Care Veterinarian: _____ **Clinic Name:** _____

Address: _____ **Clinic Number:** () _____
Street and Number City St Zip

All charges are to be PAID IN FULL at time of service. A DEPOSIT is required on hospitalized cases with balance due at time of discharge. The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the state of Alabama or any other state.

Method of Payment: Cash _____ Check _____ Master Card _____ Visa _____ Am Ex _____ Discover _____ Care Credit _____

Signature of Owner or Authorized Agent

Date