



# Monroe

VETERINARY ASSOCIATES

Thank you for giving us the opportunity to care for your pet.  
So that we may be better able to meet your needs,  
please complete the following:

Dr. Owner(s) \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
 Mr. \_\_\_\_\_  
 Mrs. Address \_\_\_\_\_  Own  Rent Employment \_\_\_\_\_  
 Ms. City / State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 E-mail \_\_\_\_\_ Do you prefer reminders be sent via e-mail?  Yes  No

The undersigned acknowledges receiving services and certifies that I will take financial responsibility. In the event that payment is not received and my account is placed for collection, the undersigned agrees to pay in addition to the amount due, service charges, in the amount of 1.5% per month (18% per annum), an amount equal to all collection expenses, including reasonable attorney's fees in the amount of 33-1/3% of the amount placed for collection. I authorize the Animal Hospital to check my credit record and to verify my credit, employment and income references.

Witness \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

### All fees are due upon rendering of services.

How did you become aware of our hospital?  Yellow Pages  Clinic Sign/Location  Online  Other Media

Personal Recommendation \_\_\_\_\_  
Name Address

Friend  Family  DVM  Other Hospital

Have you ever been to a Veterinarian before?  Yes  No If so, where? \_\_\_\_\_

Is there a particular area of interest that we could possibly provide you with more information?  
 \_\_\_\_\_  
 \_\_\_\_\_

### Please list all pets, whether or not they have an appointment with us today

**NOTE: For the safety of all animals and staff, it is our policy that all animals must be up to date with their vaccinations in order to be boarded or hospitalized.**

<b>Patient 1 Name</b>	<input type="checkbox"/> Dog	Breed _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	<input type="checkbox"/> Cat	Color _____	Spayed/Neutered: <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Other		Birth Date _____
Vaccination Date/Year: _____			
<input type="checkbox"/> Dog	Rabies _____	Distemper/Parvo _____	<input type="checkbox"/> Cat Rabies _____ Distemper _____ Feline Leukemia _____
Other _____		Where Given _____	
Diet _____		Reason for Visit _____	
<b>Patient 2 Name</b>	<input type="checkbox"/> Dog	Breed _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	<input type="checkbox"/> Cat	Color _____	Spayed/Neutered: <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Other		Birth Date _____
Vaccination Date/Year: _____			
<input type="checkbox"/> Dog	Rabies _____	Distemper/Parvo _____	<input type="checkbox"/> Cat Rabies _____ Distemper _____ Feline Leukemia _____
Other _____		Where Given _____	
Diet _____		Reason for Visit _____	
<b>Patient 3 Name</b>	<input type="checkbox"/> Dog	Breed _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	<input type="checkbox"/> Cat	Color _____	Spayed/Neutered: <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Other		Birth Date _____
Vaccination Date/Year: _____			
<input type="checkbox"/> Dog	Rabies _____	Distemper/Parvo _____	<input type="checkbox"/> Cat Rabies _____ Distemper _____ Feline Leukemia _____
Other _____		Where Given _____	
Diet _____		Reason for Visit _____	