



ivarro Small Animal Clinic

Client Information

Dr / Mr / Mrs / Ms Last Name: _____ First Name: _____

Dr/ Mr / Mrs / Ms Spouse Full Name: _____

Mailing Address: _____

Street/Apt # City/State/Zip

Home Phone: _____ Cell Phone #1 : _____ Cell Phone #2: _____

His Employer: _____ His Work#: _____

Her Employer: _____ Her Work#: _____

Email Address: _____

Previous Veterinarian: _____ May we call for records? YES NO

Alternate Contact (not living w/you): _____ Phone#: _____

How did you hear about us? Sign/Location _____ Yellow Pages _____ Facebook _____ Billboard/Ad _____

Patient Information

Pet Name	Dog	Cat	Breed	Color	Age OR Birthdate	Sex	Spayed or Neutered	Is your pet Microchipped
						Male Female	Yes No	Yes No
						Male Female	Yes No	Yes No
						Male Female	Yes No	Yes No
						Male Female	Yes No	Yes No

PAYMENT IS DUE IN FULL AT TIME OF VISIT. A deposit is required for extensive or emergency procedures, with balance due at time of release. There is a \$35.00 service charge on all returned checks.

To prevent the spread of parasites and infectious diseases, all hospitalized and boarding patients must be current on vaccinations and free of internal and external parasites. Your signature authorizes the doctor to provide these vaccinations and/or bathing/parasite control as needed.

By signing below, you authorize your pet's medical records to be released to city/state officials, requesting veterinarians/clinic/hospitals and your pet's name and photo used on our Facebook page and/or hospital publications (your last name WILL NOT be used).

How will you be paying today? __Cash __Check(TX DL# required) __Visa __Mastercard __Discover __Amex __Care Credit

I am the owner (representative) of the animal(s) listed above and will be responsible for payment of services rendered. In the event that collection efforts become necessary, I agree to pay for the costs of interest, collections, attorney's fees, and court costs.

Signature _____ Date _____