

PT# _____


Animal Clinic
 of Rockford

ACR# _____

MICROCHIP: YES NO - Num. Below

Please Fill Out Completely –	
Owner's Name: _____	Pet's Name: _____
Secondary name on account: _____	Dog Cat Other
Street Address: _____	Breed: _____
Zip Code & County: _____	Colors: _____
Phone No 1: _____	Age Estimate Date of Birth (if Known)
Phone No 2: _____	Male Female
Annual Vaccine Reminders are done via e-mail to keep the clinic as paper-lite as possible; please put your email below - it will not be used elsewhere	Neutered Spayed
E-mail (Annual Reminders): _____	
<u>VACCINATIONS ARE MEDICALLY REQUIRED TO BE IN HOSPITAL</u>	
ARE PET'S SHOTS (RABIES AND DISTEMPER / PARVO) UP TO DATE?	YES NO
WHEN AND WHERE WERE THEY LAST DONE? _____	
<u>We do not accept checks or take payment plans other than care credit; all major credit cards are accepted.</u> Payment IS DUE at time of service. What is your preferred method of payment? Care Credit Cash Credit/Debit Card	

HOW DID YOU HEAR ABOUT US? IF FRIEND/FAMILY, WHO RECOMMENDED YOU? _____

Known Medical Conditions: _____

Current Medication Pet is on: _____

Other Pets in Household – Number & Species _____

ARE YOUR PETS INDOOR / OUTDOOR OR BOTH? _____

HAS YOUR PET BITTEN ANYONE IN THE LAST 10 DAYS? **YES OR NO**DO YOU GO CAMPING / OTHER OUTDOOR ACTIVITIES WITH YOUR PET? **YES OR NO**
 We like to have patient photos in our pet medical file, which are kept within the clinic unless you consent -- are you alright with occasional cute photos to be shared on social media? **YES OR NO**
BEHAVIOR ISSUES THAT CONCERN YOU? _____**REASON FOR YOUR CURRENT VISIT?** _____
See reverse side for Client Service Agreement

Client Service Agreement

I, the undersigned, am authorizing the staff of Animal Clinic of Rockford to administer treatment, perform diagnostic and prophylactic procedures, and care for my pet(s). I consent to the administration of medications, including analgesics, sedatives, tranquilizers, anesthetics as may be deemed necessary by the attending veterinarian.

I understand that in order to maintain an appropriate veterinarian-client-patient relationship my pet needs to be examined annually by the DVM. I further understand that ongoing medical conditions may require additional examinations in order for the DVM to have sufficient knowledge of your pet's condition in order to maintain the veterinarian-client-patient

I acknowledge that no assurance, guarantee, or warranty has been made as to the results of treatments, procedures, or surgery. I am aware that every surgical procedure, treatment, and anesthesia, even performed on a healthy animal, carries a certain amount of risk and probabilities of complications. I understand that the staff of Animal Clinic of Rockford will make every reasonable attempt to safely and proficiently care for my pet. Animal Clinic of Rockford or its staff will not be held responsible in any manner whatever or any circumstance, on account of the care, treatment, or safe keeping of my pet, or otherwise in connection therewith.

Pets that remain in the clinic for 24 hours past the discharge date, without notification by, communication with, or pre-arrangement by the owner will be considered abandoned. I hereby acknowledge that I realize that pets, which are considered abandoned, will be disposed of as deemed necessary by Animal Clinic of Rockford and I will be responsible for all fees incurred.

I authorize ACR or its agents to release my pet's records to boarding facilities, groomers, and other entities that we deem have a legitimate reason for needing that information.

I bear full financial responsibility for any and all costs incurred for the treatment and care of my pet, and I am aware that all outstanding accounts are payable in full when services are rendered. Payment can be made by cash, Care Credit, or most major credit cards.

I have read and acknowledge the above statements _____
Signature Date

Authorized Agents

I, the abovesigned, name the following individuals as authorized agents regarding the care of my pet by Animal Clinic of Rockford. These people will be able to make medical decisions regarding my pet's health.

_____ Agent Name	_____ Contact Number	_____ Own. Init.
_____ Agent Name	_____ Contact Number	_____ Own. Init.
_____ Agent Name	_____ Contact Number	_____ Own. Init.