

New Client/Patient Information

The information you provide on this form is confidential and only for the use of PMC & its agents.

Tell us about you! (Please Print Clearly)

ID Number (for office use only) _____

Your Name _____

Your Date of Birth ____ / ____ / ____ (DOB required by FDA for certain prescriptions)

Drivers License # _____ Exp. ____ / ____ / ____ (DL required for check transactions)

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext. _____

Cell Phone _____ (Please place an “ * ” next to your PRIMARY phone #.)

Email Address _____ @ _____

Would you like to be sent reminders for your pet(s) via this e-mail address? Yes / No

Who else is responsible for your pet?

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Ext. _____

Cell Phone _____ Other Phone _____

How did you hear about us?

Our Website: www.petmedcenterfresno.com

Yellow Pages Ad

Our Location

Pac Bell / AT&T (Please Circle One)

Individual* _____

KSEE 24 News

Veterinary Practice _____

Other _____

Individual – Please print the name of person who referred you on the line provided

Tell us about your pet! If you have additional pets please request another form!

Pet name _____ Date of Birth/Approx. Age _____

Species: Feline / Canine / Other _____ Breed _____

Male / Female - Spayed / Neutered / Unaltered (Please circle) Color and Markings _____

Microchip Number _____ Pet Insurance Company _____

No Microchip? Would you like information? Yes/No No pet insurance? Would you like information? Yes/No

Previous Veterinarian _____ Would you like us to request your pet's medical records? Yes/No

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE RENDERED.

WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, AND CARE CREDIT.

Signature of owner _____ Date _____

Patient ID: _____

**RESTRAINT BY OWNER WHEN NO ANCILLARY
VETERINARY ASSISTANCE IS AVAILABLE**

I _____ understand that the restraint of my animal(s) during examinations and basic treatments offered by **PET MEDICAL CENTER AND SPA** involve some risk of injuries to myself, my animal(s), agent of mine, and/or the staff. These injuries can occur from various causes including, but not limited to, bites, kicks, and sudden movements. As an animal owner, I am fully aware of such risks and understand that because of **PET MEDICAL CENTER AND SPA'S**, ambulatory style of veterinary practice, I may or will be required to assist with the restraint of such animal(s).

I am or have been made aware that in some cases my animal(s) may need to be sedated or anesthetized to provide for its', their, the doctor's/staff's, my agent's, and/or my safety. I have been informed or am aware that while other veterinary practices may provide support staff to restrain or assist in the restraint of animals, such assistance generally is not available with veterinary care provided by veterinarians and/or staff at **PET MEDICAL CENTER AND SPA**.

Nevertheless, I hereby request that the veterinarians and/or staff at **PET MEDICAL CENTER AND SPA** proceed with examinations and appropriate treatments. I agree to assume the risks and responsibilities for the occurrence of any injury or other mishap caused by my animal(s) to itself, themselves, my agents, and/or myself as a result of this decision. In the event my animal(s) has/have shown aggressive behavior toward people or other animals, I agree to advise the veterinarians and/or staff at **PET MEDICAL CENTER AND SPA** of such behavior before restraint and/or medical care is initiated. I understand that my signature hereunder pertains to all animals owned by me and is not limited to the one or more being examined at the time of this visit.

Signature of owner or agent

Date

Printed name of owner or agent