



# North Main Small Animal Clinic, P.C.

1504 North Main Street; Blacksburg, VA 24060

(540) 951-1002

## Client-Patient Information Sheet

### Owner Information

Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
 Local Address \_\_\_\_\_ Best time to call? am PM any  
 City, State, Zip \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Ext. \_\_\_\_\_  
 Permanent Address \_\_\_\_\_ Employer \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ College Student? Yes No  
 SS# or Driver's License ID# \_\_\_\_\_ Graduating in what year? \_\_\_\_\_

Please inform us of any changes in the information above so we may keep records up to date. Thanks!

### Pet Information

Name \_\_\_\_\_ Breed \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_\_ Cat \_\_\_\_\_ Dog \_\_\_\_\_ Other \_\_\_\_\_  
 \_\_\_\_\_ Color and Markings \_\_\_\_\_  
 \_\_\_\_\_ Is your pet...? \_\_\_\_\_ Male \_\_\_\_\_ Intact \_\_\_\_\_ Neutered  
 \_\_\_\_\_ Female \_\_\_\_\_ Intact \_\_\_\_\_ Spayed

### Medical History:

Does your pet see another vet?  No  Yes, Clinic Name & City? \_\_\_\_\_  
 .....have allergies to  Fleas  Drugs  Other Explain: \_\_\_\_\_  
 .....have chronic medical problems?  No  Yes, Explain: \_\_\_\_\_  
 .....currently take medications regularly?  No  Yes, what kind? \_\_\_\_\_

### Vaccines and tests -- please give dates (mo/yr)

Cats: FVRCP (distemper) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 FELV (leukemia) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 FELV Test \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Dogs: DHLPP-C (distemper-parvo) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Bordetella (kennel cough) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Heartworm Test \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Use Heartworm Medicine?  Yes  No

Rabies Vaccine Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  1yr  3yr

Any other vaccines or tests? \_\_\_\_/\_\_\_\_/\_\_\_\_

Pet's last fecal examination? \_\_\_\_/\_\_\_\_/\_\_\_\_ Deworming? \_\_\_\_/\_\_\_\_/\_\_\_\_

## Statement of Financial Responsibility and Treatment Authorization

I hereby authorize the veterinarian on duty and his/her designated assistants to provide medical and/or surgical treatment for the above named pet as deemed necessary by physical and/or laboratory examination. I understand that such treatments will be done with my prior knowledge and consent except in cases of life-threatening emergency requiring immediate action.

I agree to assume financial responsibility for all charges incurred for services rendered, and I understand that full payment is required at the time of service or upon discharge. (Payment methods include cash, Visa, Master Card, and personal check for accounts in good standing.)

In the event that nonpayment of my account results in referral to an attorney or collection agency, I agree to pay an amount equal to the balance due plus reasonable attorney fees in addition to all fees for use of a collection agency as well as any court costs. Venue for all actions shall be Montgomery County. Any defense of the claim of statute of limitations is hereby waived.

Date \_\_\_\_\_ Signature of Owner/Representative \_\_\_\_\_  
 Witness \_\_\_\_\_