

Thank you for giving us the opportunity to care for your pet! To ensure the best care possible, please take the time to fill in this form completely.

Owner's Name: _____ Spouse's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Owner's Cell: _____ Spouse's Cell: _____

Email Address: _____

*By providing your cell phone number and email address, we will remind you of your pet(s) upcoming appointments.

Owner's Employer: _____ Work Phone: _____

Spouse's Employer: _____ Work Phone: _____

How did you hear about us? Internet Our website Bradenton Veterinary Emergency Sign/Driving By
 Referred by someone? Name: _____

Records Release

Florida statute allows us to discuss and share your pet's patient records with other veterinarians with whom we are conferring about your pet's care. For example, we may want advice from a specialist. Other situations do require written consent for the transfer of patient records.

Please **CHOOSE ONE** of the following options:

- I **DO AUTHORIZE** the release of my pet's medical records without restriction to any veterinary practice, boarding kennel, or any other animal care facility making the request.
- I **DO NOT AUTHORIZE** the release of my pet's patient records without specification of the recipient. I understand that this will require an additional form to be signed at the time of transfer.

Name of Pet(s): _____

Social Media Release

I grant to DeSoto Animal Clinic, its representatives and employees, the right to take photographs of me and/or my pet(s), and to copyright, use, and publish the same in print and/or electronically. I agree that DeSoto Animal Clinic may use such photographs of me and/or my pet with or without my name and for any lawful purpose, including for example, such purposes as publicity, illustration, advertising, and web content.

- I **ALLOW** the above to take photos of me and/or my pet(s)
- I **DO NOT ALLOW** the above to take photos of me and/or my pet(s)

Payment Policy

We will gladly prepare a written estimate of service fees if needed (*ask a staff member*). Payment is due in full when services are rendered. We accept all major credit cards, cash, and checks (there is \$25 service charge for any returned checks). Any payment agreements are in the form of CareCredit.

Please provide your driver's license for confirmation of ownership of your pet(s) and payment identification.

Signature of Owner: _____ Date: _____

**** Please turn page over to complete your pet(s) history. ****

PET(S) HISTORY INFORMATION

Pet's Name: _____ **Species:** Canine Feline Other: _____

Breed: _____ **Color:** _____ **Date of Birth/Age:** _____

Sex: Male Female **Neutered / Spayed:** No Yes

Indicate Date for the following items:

Last Exam: _____ **Rabies Vacc:** _____ **DA2PP / FVRCP:** _____

Intestinal Parasite Screen: _____ **Heartworm Check:** _____

Does your pet have a microchip implant? No Yes **If yes, #:** _____

Pet's Usual Diet / Treats (indicate brand name): _____

Any Children in Household? No Yes

Does your pet go outside? No Yes → **How long & often?** _____

Is your pet on preventatives for heartworm &/or fleas/ticks? No Yes, what? _____

Does your pet take any medication(s)? No Yes **If yes, what?** _____

Does your pet have any allergies? No Yes Food Skin Other: _____



Pet's Name: _____ **Species:** Canine Feline Other: _____

Breed: _____ **Color:** _____ **Date of Birth/Age:** _____

Sex: Male Female **Neutered / Spayed:** No Yes

Indicate Date for the following items:

Last Exam: _____ **Rabies Vacc:** _____ **DA2PP / FVRCP:** _____

Intestinal Parasite Screen: _____ **Heartworm Check:** _____

Does your pet have a microchip implant? No Yes **If yes, #:** _____

Pet's Usual Diet / Treats (indicate brand name): _____

Any Children in Household? No Yes

Does your pet go outside? No Yes → **How long & often?** _____

Is your pet on preventatives for heartworm &/or fleas/ticks? No Yes, what? _____

Does your pet take any medication(s)? No Yes **If yes, what?** _____

Does your pet have any allergies? No Yes Food Skin Other: _____



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