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 www.rosrockvethospital.com
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 "Loving Care for Your Pet"

Welcome To Our Practice

Thank you for giving us the opportunity to care for your pet(s). Please help us meet your needs better by taking a moment to share some important information we will need as we support your pet(s) needs today and in the future. *Please print in ALL SPACES.*

Client's Name (Mr., Ms., Dr.) _____ Spouse (Mr., Ms., Dr.) _____

Mailing Address _____ City _____ St _____ Zip _____

Physical Address _____ City _____ St _____ Zip _____

Email Address _____

Others Authorized to Do Business on Your Account _____

Home Phone _____ Cell _____ Spouse's Cell _____

Employer _____ Work Phone _____

Spouse's Employer _____ Work Phone _____

Drivers License _____ State _____ Spouse Drivers License _____

How did you hear about us? AT&T YellowBook UserFriendly Phonebook Norman Reg. Phonebook Newspaper Sign
 Website Facebook Twitter Google Google Ad YouTube 360OKC Norman Chamber
 LocalVets Yelp FourSquare Animal Shelter Dog Park Mamaveca Craigslist
 Referred By _____ Other _____

Is your pet(s) insured? (Please Circle) Yes No Company _____ Policy # _____

We will gladly prepare a written treatment plan if you desire. This will be important to you since **ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.** If your pet is hospitalized, a deposit may be required upon entry and the remaining balance is due immediately upon discharge. There will be a \$25.00 service charge for any check returned. A \$3.00 or 21.9% per annum fee (greater of two) will be added to all unpaid balances monthly. Signature below accepts these terms and accepts responsibility for all charges incurred in the treatment of pet(s) or any applicable attorney's fees or additional charges incurred in the treatment of pet(s) or any applicable attorney's fees or additional charges incurred in the collection of payment. We accept CASH, CHECK (Driver's License Required), VISA, MASTERCARD, DISCOVER, and CARE CREDIT. To prevent the spread of infectious diseases, all hospitalized and boarded patients must be current on all vaccines and free from internal and external parasites. The signature below authorizes this level of preventative care and the appropriate charges will be assessed in the discharge invoice.

_____ (Initials) **I authorize the release of my phone number and/or address in the event someone calls in with information from my pet's rabies tag.**

_____ (Initials) **I authorize medical records for all my pets to be released to other boarding facilities or veterinary hospitals.**

I HAVE READ THE ABOVE STATEMENT AND I AM IN FULL AGREEMENT. THIS AGREEMENT IS IN FORCE UNTIL I, THE UNDERSIGNED, REVOKE SUCH AGREEMENT IN WRITING.

Signature of Responsible Agent for Pets _____ **Date** _____

Essential Pet Information

Pet's Name	Species (ex: K9)	Sex (male, female)	Altered (spayed/neutered)	Breed	Color	Date of Birth/Age	Date Last Vacc.	Micro-Chipped?

Prior veterinarian where records could be obtained? _____

Thank you for choosing Rose Rock Veterinary Hospital & Pet Resort. We hope we meet your satisfaction. If we do not, please let us know how we could better serve you and your pet(s) needs.