



Welcome To Our Practice

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

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

Address _____ City _____ St _____ Zip _____

Children/Others Interacting with Pet(s) _____ Email Address _____

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 Website Facebook Dog Park YellowBook Twitter Animal Shelter User Friendly Phonebook Google Referred By Norman Regional Phonebook YouTube 360OKC Other Sign Google Ad Norman Chamber

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 (Drivers License Required 1st time only), and VISA/MC/DISCOVER/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.**

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

Essential Pet Information

Species (circle)	Pet's Name	Date of Birth/Age	Sex (Circle)	Breed	Color	Date Last Vacc.	Micro-chipped
Dog Cat Other			Female Male Spayed Castrated				Yes No
Dog Cat Other			Female Male Spayed Castrated				Yes No
Dog Cat Other			Female Male Spayed Castrated				Yes No
Dog Cat Other			Female Male Spayed Castrated				Yes No

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 pets needs.