

VETERINARY SURGERY OF BIRMINGHAM

CLIENT INFORMATION

NAME: _____ DATE: _____
 FIRST MIDDLE INT. LAST
SPOUSE/OTHER: _____ (SP./OTHER PHONE: _____)
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ CELL PHONE: _____
EMPLOYER: _____ BUSINESS PHONE: _____

PET INFORMATION

PET'S NAME: _____ DOG CAT OTHER
AGE/BIRTH DATE: _____ SEX MALE FEMALE
BREED: _____ COLOR: _____
NEUTERED/SPAYED: YES NO
CURRENT BLOODWORK (WITHIN LAST 3 MONTHS): YES NO
XRAYS: YES NO
IS YOUR PET CURRENT WITH VACCINATIONS? YES NO
REFERRING VETERINARIAN NAME: _____
CLINIC NAME: _____
CLINIC TELEPHONE: _____ FAX: _____
REASON FOR VISIT: _____

PAYMENT

ALL PROFESSIONAL FEES ARE DUE WHEN SERVICES ARE RENDERED.
WE DO NOT BILL. WE DO NOT ACCEPT PERSONAL CHECKS.
WE DO ACCEPT VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, AND CASH.

CLIENT SIGNATURE: _____ DATE: _____