Victoria Veterinary Clinic *File # _____*

FOR CONSENT PURPOSES, OWNER MUST BE AT LEAST 18 YEARS OLD

Client Information

Owners Name (/Mr./Mrs./Ms./Dr.)_____
First Last

Address _____
Street

_____ _____ _____
City Province Postal Code

Phone #'s (____) _____ **(____)** _____ **(____)** _____
Cell Residence Business

Spouse/Relative/Other (Mr./Mrs./Ms/Dr.) _____
First Last

Phone #'s (____) _____ (____) _____
Cell Business

Would you like us to send you Reminders by: □ Mail □Email: _____

Patient Information

Pet's Name _____ **Birthdate** _____ **□ Female □ Male**
(Or approximate age)

Breed_____ **Color** _____ **Spayed/Neutered? □ No □Yes**

Microchip: □No □Yes #:_____ **Tattoo: □No □Yes #:**_____

Has your pet had any previous vaccinations? □ No □Yes (if yes, explain below)

Vaccines administered? (If known) _____

When? _____ Where? _____

I consent to Victoria Veterinary Clinic contacting my previous veterinarian for my pet's medical history □ Yes □ No

Does your pet have any previous or existing medical conditions, injuries, or has had any major surgeries? □ No □ Yes

Describe _____

Does your pet have any allergies to foods, vaccinations, or medications? □ No □Yes _____

Is your pet on any special diets? □No □Yes _____ Medications? □No □Yes _____

I consent to the use of images or video of my pet for promotional or editorial use: □Yes □No

How did you learn about our practice? (Please circle) Phone Book Location Website Other: _____

Referral – Who may we thank? _____

I understand that professional fees are to be paid at the time that they are rendered.
(For your convenience, Victoria Veterinary Clinic accepts CASH, DEBIT, MASTERCARD and VISA)
I authorize treatment for the patient named above and accept responsibility for the charges incurred at this hospital.

_____ _____

Signature of Owner or Authorizing Agent **Date**