

# PET/OWNER INFORMATION FORM

FILE ID: \_\_\_\_\_

## FREMONT VETERINARY CLINIC

2223 E. FREMONT STREET, STOCKTON, CA 95205

Ph. 209-465-7291 Fax 209-465-7438

www.fremontveterinaryclinic.com

Today's Date: \_\_\_\_\_

Driver's License or I. D. Card Number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Name: \_\_\_\_\_

How did you hear about Us?

Yellow Pages \_\_\_\_\_ Internet \_\_\_\_\_ Hospital Sign \_\_\_\_\_ Referred by \_\_\_\_\_

Address: \_\_\_\_\_  
Street number and name City State Zip Code

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Telephone numbers:

Home : (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work : (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell : (\_\_\_\_) \_\_\_\_ - \_\_\_\_

E-mail: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_  
Name Phone

### PETS INFORMATION:

SPECIES (DOG/CAT) \_\_\_\_\_

1. Name: \_\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Pet's Date of Birth: \_\_\_\_\_ Sex (Male/Female): \_\_\_\_\_ Spayed/Neutered: (Y/N) \_\_\_\_\_

Previous vaccination (Yes /NO) \_\_\_\_\_

Canine Distemper / Parvo / Rabies \_\_\_\_\_

Feline Distemper / Feline Leukemia / Rabies \_\_\_\_\_

Date of previous vaccination: \_\_\_\_\_ Microchipped (Yes/No): \_\_\_\_\_

Other Person who may authorize treatment for your pet: \_\_\_\_\_  
Name Phone

### PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE PERFORMED

- In admitting my pet(s) for diagnostics, treatment, or surgery, I authorize the Dr's. of **Fremont Veterinary Clinic** and their support staff, to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary.

Please Turn Over The Page

- It is understood that an estimate of charges will be given for services. No guarantee or assurance can be made as to the results that may be obtained.
- I agree to pay, in addition to any other sums allowed by law, a \$25.00 service charge in the event that a check is dishonored.
- Type of payment you will be using: Visa \_\_\_\_\_ MasterCard \_\_\_\_\_ Check \_\_\_\_\_ Cash \_\_\_\_\_  
American Express \_\_\_\_\_ Discover \_\_\_\_\_
- Further, I understand that a deposit of 50% is required before services are performed and I assume full financial responsibility for all charges incurred by my pet. I realize that these charges may exceed a given estimate if complications arise. I understand that I will be contacted prior to treatment, if possible, should complications occur.

Signature: \_\_\_\_\_

Thank you and we look forward to serving you and your pet.

The Dr's. & Staff of Fremont Veterinary Clinic