Client Information

Owner Name:_____ Co-Owner/Spouse Name:_____

Home Address:_____

City:_____State:_____ Zip:_____ **Primary Phone #**:_____

Secondary Phone #:_____ Co-Owner Phone #:_____

Email Address:_____ Employer:_____

Driver's Lic#_____DOB:_____ Work Phone:_____

We must collect Driver's License and employment information for collection purposes. We also require a photocopy of your license

Patient Information

Patient Name:_____ Dog _____ Cat_____ Breed:_____

Circle One: Male/Intact Male/Neutered Female/Intact Female/Spayed

Birth Date/Age:_____Color:_____ Are Vaccinations Current? Y / N

Reason for Referral (primary complaint):_____

Please list any of your pet's drug allergies or special problems that we should know about:

_____

What veterinarian referred you to Arkansas Veterinary Emergency & Specialists?_____

Had you heard about our hospital prior to this referral? Yes_____ No_____ If yes, how:_____

Did you bring (or mail in) X-rays and/or medical records from your veterinarian? Yes_____ No_____

OFFICE USE ONLY

RDVM Name:_____ **Clinic Name**:_____

Clinic Phone:_____ **Clinic Fax**:_____

Payment Information

I understand that I am financially responsible to Arkansas Veterinary Emergency & Specialists for charges. I understand that payment is due in full at the time services are rendered. I agree to pay all interest, collection, legal, attorney or court fees in the event it becomes necessary to pursue the account for collection. We accept cash, checks, major credit cards and Care Credit. TeleCheck authorizes all checks. When you provide a check as payment, you authorize us to use information from your check to process a one-time payment Electronic Funds Transfer (EFT), a draft drawn from your account or to process the payment as a check transaction. Unless specifically requested, all pets needing emergency care while staying in our hospital will be treated until the owner/agent can be contacted.

_____ _____

Owner/Agent Signature (must be over 18 years of age) **Date**