DERMATOLOGY
& ALLERGY CLINIC
FOR ANIMALS

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Thank you for giving us the opportunity to care for your pet(s). To better help us meet your needs, please take a moment to complete this information. This information will be kept confidential.

Date: _____

First Name: _____ Last Name: _____

Spouse's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: _____ Cell/Work Phone: _____

Pet Information

Pet Name: _____

Species (please select one) ☐ Dog ☐ Cat ☐ Equine

Breed: _____ Sex: _____ Spayed / Neutered / Intact

Age: _____ Date of Birth: _____ Color: _____

Referring Hospital(s):

_____

_____

Please check if you allow Dermatology and Allergy Clinic for Animals to photograph your pet and post them to our business Facebook Page.

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet. I assume full responsibility for all charges incurred for the care of this animal. I also understand that these charges will be paid at the time services are rendered.

This veterinary facility does not provide supervision for patients after normal business hours

Signature: _____ Date: _____