CYPRESS VIEW VETERINARY CLINIC

PLEASE HELP US MEET YOUR NEEDS BY TAKING A MOMENT TO COMPLETE THIS QUESTIONNAIRE AND RETURN THIS COMPLETED AND SIGNED SHEET TO THE FRONT DESK PERSON YOU CHECKED IN WITH.

OWNER'S FIRST NAME(S): _____ LAST NAME _____

MAILING ADDRESS: _____ CITY _____ POSTAL CODE _____

PHONE NUMBERS: Home: _____ Work: _____ Employer: _____ Cell: _____

*E-MAIL ADDRESS: _____

(To allow us to share appointment reminders, vaccination due date reminders and appointment scheduling on-line)

1. PET'S NAME: _____ CAT ____ DOG____ BREED: _____

   COLOR: _____ BIRTHDATE (IF KNOWN)_____ ESTIMATED AGE: _____

   MALE/FEMALE: _____SPAYED/NEUTERED_____ MICROCHIPPED: YES/NO TATTOOED: YES/NO

   PREVIOUS CLINIC(S):_____

   PLEASE LIST YOUR CURRENT FOOD FOR YOUR PET: _____

   PLEASE LIST ANY MAJOR ILLNESSES/DISEASES YOUR PET HAS (I.E. DIABETES):

   _____

   _____

   PLEASE LIST ANY CURRENT MEDICATIONS YOUR PET IS ON (PRESCRIBED OR HERBAL):

   _____

2. PET'S NAME: _____ CAT ____ DOG____ BREED: _____

   COLOR: _____ BIRTHDATE (IF KNOWN)_____ ESTIMATED AGE: _____

   MALE/FEMALE: _____SPAYED/NEUTERED_____ MICROCHIPPED: YES/NO TATTOOED: YES/NO

   PREVIOUS CLINIC(S):_____

   PLEASE LIST YOUR CURRENT FOOD FOR YOUR PET: _____

   PLEASE LIST ANY MAJOR ILLNESSES/DISEASES YOUR PET HAS (I.E. DIABETES):

   _____

   _____

   PLEASE LIST ANY CURRENT MEDICATIONS YOUR PET IS ON (PRESCRIBED OR HERBAL):

   _____

See Over ⟹

HOW DID YOU HEAR ABOUT US? PLEASE CHOOSE FROM THE LIST BELOW

SOCIAL MEDIA FAMILY FRIEND NEWSPAPER RADIO TELEVISION

OTHER _____

IF YOU WERE REFERRED TO OUR CLINIC, WHO REFERRED YOU?_____

PHONE #_____

OUR PAYMENT POLICY

PAYMENT IS DUE WHEN SERVICES ARE RENDERED. HOSPITALIZED CASES WILL NOT BE RELEASED WITHOUT PAYMENT. WITH EMERGENCY CASES, OR WHERE A LARGE BILL IS ANTICIPATED, A DEPOSIT WILL BE REQUIERD. WE WILL NOT REFUSE TREATMENT TO ALLEVIATE PAIN AND SUFFERING.

WE ACCEPT THE FOLLOWING FORMS OF PAYMENT: CASH, DEBIT, VISA AND MASTERCARD.

YOU MUST NOTIFY US IN ADVANCE OF TREATMENT, IF YOU ANTICIPATE YOU WILL BE UNABLE TO MEET OUR PAYMENT TERMS

I HEREBY ACKNOWELDGE THAT I HAVE READ AND UNDERSTAND YOUR PAYMENT POLICY.

SIGNATURE: X_____

PERMISSION

I, THE UNDERSIGNED, DO HEREBY GIVE THE CLINIC PERMISSION TO (PLEASE CROSS OUT ANY OF THE CHOICES BELOW THAT YOU WOULD NOT GIVE YOUR PERMISSION FOR).

1. RELEASE INFORMATION REGARDING THE VACCINATION STATUS OF MY PET(S) TO KENNELS, GROOMERS OR OTHER VETERINARY CLINICS;
2. TO RELEASE MY ADDRESS AND/OR PHONE NUMBER IN CASE MY PETS ARE LOST OR FOUND.
3. TO USE PHOTOS OF MY PET(S) ON THE CYPRESS VIEW WEB PAGE OR FACEBOOK.
4. FOR CYPRESS VIEW VETERINARY CLINIC TO KEEP MY E-MAIL ADDRESS ON FILE FOR THE PURPOSE OF SENDING APPOINTMENT REMINDERS, ACCOUNT STATEMENTS OR OTHER REQUESTED DOCUMENTS.
5. TO SEND COPIES OF RECORDS TO OTHER VETERINARY CLINICS WHEN REQUESTED OR REQUIRED FOR REFERRALS.
6. (IF APPLICABLE) TO RELEASE MY NAME AND PHONE NUMBER IF MY PET(S) CAN BE USED FOR BREEDING PURPOSES OR IF I HAVE PUPPIES OR KITTENS FOR SALE.

DATE: _____SIGNATURE: X_____ PRINT NAME:_____

IF YOU WOULD BE INTERESTED IN RECEIVING OUR MONTHLY NEWSLETTER, PLEASE PROVIDE YOUR

E-MAIL ADDRESS HERE: _____