Fox Memorial Clinic

Patient and Owner information

Owner's Name: ____

Authorized Person(s) to act on my behalf (must be 18 years of age or older):

____

Address(NO P.O.Boxes) ______________________City__________ ST___ Zip______

Phone Numbers: Home: __________ Work: __________ Cell: __________

Text Message Number: __________ E-mail Address: ____________________

Pet's Name (patient): ____________________ Age/DOB: __________

Species: Dog ___ Cat___ Male ___ Neutered Male ___ Female ___ Spayed Female ___

Breed: ______________ Color/Markings: ______________ Approx. Weight:_____

*Any existing medical conditions and/or medications: ______________________

____

*Allergies/Drug Sensitivities/Vaccine Reactions: ______________________

*Has your pet been known to bite or show aggression? ______________________

*Does your pet have a current rabies certificate? ______Yes (Must provide proof) _____No (My pet will need the rabies vaccination required by Connecticut State Law)

- **We accept CASH, VISA, MASTERCARD, and DEBIT ONLY** ****WE DO NOT ACCEPT CHECKS****
- During your appointment the staff will be able to provide you with an estimate for recommended services. Please let us know if you have any financial limits so that we may work within your budget.

____ *initials* *I hereby authorize the veterinarian to examine, prescribe for, or treat the above-described pet. I assume responsibility for all charges incurred in the care of my animal. I also understand all professional fees are due at the time services are rendered.*

Do you give us permission to use your name, your pet's name and any photos for publicity and/or as a testimonial? Our way to continue to provide the veterinary care that the community needs is by word-of-mouth referrals, so we value your input and hope to use it to help others. Yes ____ No ____

I attest that the above pet is owned by me, and I authorize the Fox Memorial Clinic to release any medical records upon my request. Yes ____ No ____ (Fees may apply)

Signature of owner/agent: ______________________ Date: __________