

Tequesta Veterinary Clinic, LLC

Owner's Name (s): _____

Address: _____ City: _____ Zip: _____

Email address (es): _____

Home Phone: _____ Spouse Name: _____

Cell Phone (s) _____

Work Phone (s) _____

Other Emergency Contacts _____

Animal Name: _____ nicknames: _____

Dog Cat (circle one) Sex: Male Female Spayed or Neutered Y/N

Breed: _____ DOB _____ Diet fed _____

Brief history of pet & prior conditions _____

Meds this pet taking _____

Allergies/Prior adverse reactions? _____

Animal Name: _____

Dog Cat (circle one) Sex Male Female Spayed or neutered? Y/N

Breed _____ DOB _____ Diet fed _____

Brief History of pet & prior conditions _____

Meds this pet is taking _____

Allergies/Prior adverse reactions? _____

Professional fees are due at the time services are rendered.

Cash, checks, visa and mastercard are accepted.

More information is on the web at www.Tequesta Veterinary Clinic.com

Prior veterinarian and phone number _____

AUTHORIZATION FOR TREATMENT

I authorize Tequesta Vet Clinic to give treatment to the above named animal(s). I authorize them to retrieve my pet's prior veterinary records. **I understand** that vaccines are highly recommended and that there is a very low risk of adverse side effects from vaccinations. I will discuss this issue with the doctor and staff and make sure all my questions are answered. We will vaccinate based on the lifestyle of my pet. Vaccine reminders and copies of medical records are sent via email.

Signature: _____ Date: _____