LAREDO ANIMAL CLINIC
6001 MC PHERSON
LAREDO, TEXAS 78041

CLIENT/ STABLE INFORMATION SHEET

OWNER INFORMATION

NAME________________________________ SPOUSE_____________________________________

DRIVER'S LICENSE#______________________ADDRESS___________________________________

CITY __________________________________ STATE ________ ZIP___________________________

SAME AS SHIPPING ADDRESS: ___ YES ____ NO- IF NO, ADDRESS___________________________

PRIMARY PHONE # ____________________________ CELL _________________________________

E-MAIL _____________________

STABLE INFORMATION - SAME AS OWNER ADDRESS? __ YES __NO – IF NO COMPLERE THIS SECTION

STABLE NAME ____

CONTACT NAME (BARN OWNER, AGENT, MANAGER) _____________________________________

ADDRESS ____

CITY ____ STATE ___________ ZIP ____________________

PHONE (BARN) __________________________________

**I AUTHORIZE THE RELASE OF MEDICAL INFORMATION ABOUT MY HORSE (S) TO MY BARN MANAGER / AGENT ___ YES ___NO

**I AUTHORIZE MY BARN MANAGER TO ACT AS AGENT TO MKE APPOINTMENTS AND/ OR ORDER MEDICATION FOR MY HORSE(S) __ YES __ NO

Laredo Animal Clinic

BIENVENIDOS A NUESTRA CLINICA

Numero de Cuenta: ______

INFORMACION DE CLIENTE

Nombre______________________ Nombre de esposo(a)______________________

Domicilio__________________ Ciudad ______________ Zona Postal____________

Telefono __________________ Telefono del trabajo ____________________

Telefono de esposo(a) ______________ Correo Electronico ____________________

Empleo ______________________ Mejor tiempo para llamar __________________

Licencia ____________________ # Seguro Social ______________________

***** Todos los pagos se requiren al tiempo del servicio recibido******

Modo de pago: [ ] Efectivo/cheque [ ] Visa [ ] MasterCard [ ] American Express [ ] Discover

Nuestra mascota(s) es [ ] Miembro de la familia [ ] Mascota del nino [ ] Mascota de la casa

INFORMACION DE PACIENTE

Nombre____________________ Microchip# ______________________

Raza ______________________ [ ] Perro [ ] Gato [ ] Otro

Fecha de nacimiento ____________ [ ] Hembra [ ] Macho

Color ______________________ Esterilizado / Castrado [ ] Si [ ] No

Yo asumo la responsabilidad por todos los cargos incurridos en el cuidado del animal. Tambien tengo entendido que esos cargos seran pagados al tiempo de entregar al animal y que un deposito puede ser requerido para tratamiento quirurgico.

Firma de dueno/persona responsible: X______________________Fecha: ____________

Notas de Doctor:____

____

____

____

LAREDO ANIMAL CLINIC
WELCOME TO OUR PRACTICE
*****ALL FEES ARE DUE AT THE TIMES OF SERVICES RENDERED*****
ACCOUNT#________

CLIENT FORM

Name (owner) ____________________________ Spouse's Name ______________________
Address _______________________ City_______________ State________ Zip__________
Phone _______________ Work phone _____________Spouses work phone_____________
Place of employment__________________ Best time to reach you __________________
Driver's License ____________________ Social Security Number ____________________
Email Address ___________________________________
Emergency Contact Name ____________________Phone____________________________

Choice of payment [ ] cash/check [ ] Visa [ ] MasterCard [ ] American Express

Note: Please be advised of our check policy effective 08/01/12. We are happy to accept your check for products and services with the following exceptions:

1. No temporary checks accepted.
2. Out of town checks must be approved by management.
3. No post dated checks accepted for boarding or elective surgeries.
4. Returned checks NSF will be taken to the District Attorney's Office.

Patient Information

Primary reason for visit:__________________________________

Pets Name____________________ Microchip#____________________

Approximate age or DOB __________________ [ ] Dog [ ] Cat [ ] Other

Breed _________________________ [ ] Female [ ] Male

Color _________________________ Spayed/Neuter [ ] Yes [ ] No

Pet obtained from: [ ] Friend [ ] Breeder [ ] Pet Shop [ ] Humane Society [ ] Other

I assume responsibility for all charges incurred in the care of the animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Owner or Responsible Party: X ________________________ **Date:** ________________

Doctors Notes: ____

____

____

____

____

LAREDO ANIMAL CLINIC
PHYLLIS VOLTZ-CREAMER, D.V.M
6001 MC PHERSON
LAREDO, TEXAS 78041
(956)727-5031

MEDICAL CONSENT FORM

OWNERS NAME:______________________ PATIENTS NAME:_______________________

SPECIES: _________________________ BREED: ____________________SEX:_______

WEIGHT: ______ REFERRED BY: ____________________ DR:____________________

I HEREBY AUTHORIZE LAREDO ANIMAL CLINIC AND ITS AGENTS TO ADMINISTER ANESTHETICS AND

ANALGESICS TO MY PET FOR THE FOLLOWING PROCEDURES: ______________________

INITIAL HERE: ______________________

DR PHYLLIS VOLTZ-CREAMER DVM DR REBECCA RODRIGUEZ DVM DR JOHN ALEXANDER DVM DR AMANDA FLORES DVM

I FURTHER UNDERSTAND THAT THERE ARE CERTAIN RISKS ASSOCIATED WITH ALL TYPES OF ANESTHETIC AND ANALGESICS AND I AGREE TO HOLD HARMLESS TO LAREDO ANIMAL CLINIC AND ITS AGENTS AND REPRESENTATIVES FROM ANY REACTION THAT MAY OCCUR.

_________________________ **X** _________________________

SIGNATURE: LAC EMPLOYEE SIGNATURE OF CLIENT

_____________ _______________

DATE DATE

***WE RECOMMEND FOR ALL SURGERIES TO GET A PRE-SURGICAL SCREENING: A CBC AND CHEMISTRY, RECOMMEND THIS FOR SENIORS 7 YEARS AND OLDER @ $**86.00**

_______ : ACCEPT _______ : DECLINE

BEST EMAIL TO REACH CLIENT TO RECEIVE UPDATE AFTER SURGERY

____

***WE RECOMMEND PRE-SURGICAL AND POST SURGICAL PAIN MEDICATION. FELINE $15.00 AND K-9 $16.00.

______: ACCEPT _________: DECLINE