Welcome to
NORTH SHORE VETERINARY CLINIC

Welcome to our practice. Thank you for providing us the opportunity to care for you and your pets. Please help us to meet your needs by completing these forms for us. **Please print clearly.**

Client Information

Owner's Name: _____ Spouse/Other: _____ Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Work Phone: _____ Spouse/Other Work Phone: _____ Other contact: _____

Employer: _____ Spouse/Other Employer: _____

Driver's License Number: _____ State: _____

Emergency Contact

In case of an emergency and we cannot reach you or your spouse/other, please provide someone we can contact.

Name: _____ Phone: _____

Pet Information

Name: _____ Dog: ___ Cat: ___ Breed: _____

Date Of Birth: _____ Gender: Male Female Neutered: Yes No Color: _____

Date of last vaccinations or medical testing:

Dogs:

Rabies vaccination: _____
DHCP (Distemper, Parvovirus, Hepatitis) combination:_____
Bordetella vaccine : _____
Heartworm test: _____
Fecal parasite exam:_____
Blood chemistry panel:_____

Cats:

Rabies vaccination: _____
FRCPV (Rhinotracheitis, Calicivirus, Panleukapenia) vaccine: _____
Feline Leukemia vaccine: _____
FIV and FeLV test: _____
Fecal parasite exam: _____
Blood chemistry panel: _____

Please describe any medications your pet currently receives and any special needs:

_____
_____
_____

Your pet's previous veterinarian and animal hospital: _____

Fees for all services are due in full at the time they are provided.

I, the undersigned, authorize the veterinarian, technician(s), and assistant(s) whom they designate to examine the animal(s) specifically described and identified and to administer any treatment that is considered therapeutically and/or diagnostically necessary based on the findings during the course of the initial exam. I understand that the treatment of the patient will be conducted with due care and in accordance with the prevailing standards of competency in Veterinary Medicine. I assume all financial responsibility for all charges incurred to the patient and understand that all fees and charges are due in full upon completion of services and that a deposit may be required for treatment. I understand that I may pay with Cash, Check, Visa, MasterCard, Discover, or American Express and that a $35 services fee will be charged on all checks that are returned. If a check does get returned, I understand that I will not be able to pay by check in the future (unless special arrangements are made).

Please sign here: _____