Mount Vernon Animal Hospital
316 Vernedale Dr.
Mount Vernon, Ohio 43050
740-397-6958
Robert Krueger, DVM Jessica Krueger, DVM Misty Lambert, DVM Stephanie Vijan, DVM

Welcome Dog/Cat/Small Animal
Client Service Agreement

Name: ______________________________
DOB:______________ Driver License#_________
Social Security Number:_____________________ ***Required for billing or submitting check for payment!***
Spouse/Partner:____
Home Address: _________________________________
City:__________________ State:____________ Zip Code____________
Home Phone:______________ Cell:______________
Email:____________@_________

Patient Information:
Name of Pet:_______________Dog:__Cat:__Other:___ Spayed/Neuter:______
Breed:_______________Age:______Sex:______ Color:______
Vaccination History: (Check all pet has received)
Dog:____DHLPP(Distemper,Parvo,Lepto) Heartworm Test____Rabies_____ Bordatella____
Cat:____FVRCP(Respiratory Diesase) Felv___ Rabies___ FELV/FIV test_____
Prior Surgery?______ Yes, What Procedure_________________
Other Vaccinations/History:_______________________________
Medications/Supplments:____
____
Describe you patient's diet:____

Please Check any current symptoms that you have noticed with your pet:
Behavior change___ Lack of Appetite___ Depressed/Lethargic___ Weakness____ Sneezing___Coughing___
Limping___ Bleeding Gums____ Trouble Breathing____
Diarrhea____Vomiting___Scooting___Scratching___Increased Thirst/Urinations___ Loss of balance/coordination____Gagging___ Eyes Bulding or bloodshot____ Shaking Head___

Authorization and Payment

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described animal. I assume responsibility for all charges incurred in the care of this/these animals. ALL PROFESSIONAL FEES ARE DUE AT THE TIME THAT SERVICES ARE RENEDERED. We will gladyly prepard a written estimate if you desire. (Please ask our Dr. or Staff) I also understand that these charges will need to be paid in full at the time services. In case of extensive medical or surgical procedures where full payment may be difficult at discharge, our office accecpts Visa, Mastercard, American Express, and Care Credit. There will be a service charge for any check returned unpaid. Also any unpaid balance can result in a monthly service charge.

Signature:____Date_____

Additional pets:

Patient Information:
Name of Pet:_______________Dog:__Cat:__Other:___ Spayed/Neuter:______
Breed:________________Age:______Sex:______ Color:______
Vaccination History: (Check all pet has received)
Dog:____DHLPP(Distemper,Parvo,Lepto) Heartworm Test____Rabies_____ Bordatella____
Cat:____FVRCP(Respiratory Diesase) Felv___ Rabies___ FELV/FIV test_____
Prior Surgery?______ Yes, What Procedure__________________
Other Vaccinations/History:________________________________
Medications/Supplments:____
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Describe you patient's diet:____

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Medications/Supplments:____
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Limping___ Bleeding Gums____ Trouble Breathing____
Diarrhea____Vomiting___Scooting___Scratching___Increased Thirst/Urinations___ Loss of balance/coordination____Gagging___ Eyes Bulding or bloodshot____ Shaking Head___

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