



Mount Vernon Animal Hospital
316 Venedale Dr.
Mount Vernon, Ohio 43050
740-397-6958

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 Disease) 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 RENERED. We will gladly prepared 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 accepcts 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)

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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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