Spooner Veterinary Clinic
N4815 DVM Drive
Spooner, WI 54801
715-635-2874

Care Animal Clinic
10186 State Rd. 27
Hayward, WI 54843
715-634-5050

PRIMARY OWNER(S):

Name:________________________ Spouse: ________________________

Address: ____________________ City: ________________ State:_____ Zip:________

Phone:________________ Cell Phone: ________________ Work:________________

E-mail:________________ Driver's License Number: ________________ D.O.B: ________

Preferred method of payment: Cash _______ Check _______ Credit/Debit Card ______

How did you find out about our clinic? : ________________________________

Other than you/your spouse are there any other person(s) to whom you give permission to make treatment decisions for your pet?

Yes_______ No_______

If you have checked **yes,** please list the name and telephone number of the person(s) you have authorized to consent for treatment.

1: ____

2:____

I give the Doctors of the Spooner Veterinary/Care Animal Clinic my permission to stabilize my pet in an emergency situation if I am not present/available and they are unable to reach any individual listed above.

Yes _______ No_________(If **no**, please explain your preference) ________________________

The above information is applicable to all of my pets: yes ______ no ______

PATIENT INFORMATION:

Name						
Breed						
Date of Birth/Age						
Color						
Sex	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
	Neutered	**Spayed**	**Neutered**	**Spayed**	**Neutered**	**Spayed**

Any previous surgeries or serious illness? ________________________________

Any allergies to vaccinations or medications? ________________________________

Is your pet on any special diets, medications, and/orsupplements________________________

ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED

I agree to adhere to the terms set forth in this agreement. All services rendered must be paid in full at the time of service. If full payment is not made the remaining balance will incur a 2% monthly service charge and a minimum $1.00 invoicing fee for each month thereafter. After 60 days the clinic will consider the balance in default and the account will be turned over to collections.

By signing this, I verify that I have read and understand the content of this form.

Signature: Date: