



8650 W. Tropicana Ave. Ste. B-107 / Las Vegas, NV 89147
Phone: 702-871-1152 / Fax 702-262-7000

Client and Patient Information

Owner / Agent _____ Title: Mr. Mrs. Ms. Dr.
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ E-mail _____
Occupation _____ Driver's License # _____ Expiration Date _____
SSN _____

Co-Owner _____ Title: Mr. Mrs. Ms. Dr.
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ E-mail _____
Occupation _____ Driver's License # _____ Expiration Date _____
SSN _____

Referring Veterinarian :

Dr. _____ Practice _____ Phone _____
Pet's Name _____ D.O.B./ Approximate age _____
Breed: _____ Color: _____
Species: [] Male [] Neutered [] Female [] Spayed
Number of Pets in Household: Dogs _____ Cats _____ Other _____
Your Pet is: [] Indoors/Outdoors [] Indoors Only [] Outdoors Only
When outdoors, your pet is: [] Loose [] Leashed [] Fenced [] Other _____
Your pet's normal diet is: _____ Time of last meal: _____
Current Medications: _____ Last Given: Date _____ Time _____

I, the undersigned, assume financial responsibility for all charges incurred, and agree to pay all such charges at the time services are rendered or as arranged prior to examination and/or treatment. I also understand that out-of-state checks or third party credit cards are not accepted.

Owner/Agent Signature _____ Date _____
Owner/Agent Printed Name _____ Date _____