



NAME \_\_\_\_\_ SPOUSE/PARTNER \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY/STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL # \_\_\_\_\_  
\*82 (PLEASE CIRCLE IF APPLICABLE)       MAY WE CALL YOU AT WORK?

EMAIL \_\_\_\_\_ DRIVERS LICENSE# \_\_\_\_\_

EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**REFERRED BY:**

PRIMARY VETERINARIAN: NAME \_\_\_\_\_ CLINIC NAME \_\_\_\_\_

SECOND OPINION: NAME \_\_\_\_\_ CLINIC NAME \_\_\_\_\_

YELLOW PAGES       FRIEND       FAMILY       GROOMER       INTERNET       PET EXPO or other pet related event (please list): \_\_\_\_\_  OTHER \_\_\_\_\_

It is very important that your pet's primary veterinarian know what treatment and medications your pet is receiving from us. Please provide the contact information of the veterinarian that you would like to receive these progress reports.

**Primary Veterinarian Information:**

VETERINARIAN \_\_\_\_\_

NAME

CLINIC NAME

ADDRESS

PHONE NUMBER

PET'S NAME \_\_\_\_\_ SPECIES:  Canine  Feline  Equine  Other \_\_\_\_\_

SEX:  Male  Female  Spayed/Neutered  Intact BREED \_\_\_\_\_

IF EQUINE:  Mare  Gelding  Stallion BREED \_\_\_\_\_

COLOR \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ WEIGHT \_\_\_\_\_

THE ANIMAL DERMATOLOGY CLINIC SPECIALIZES IN THE TREATMENT OF ALLERGIES, EARS, AND SKIN DISEASE ONLY. IF YOUR PET HAS ANY OTHER MEDICAL OR SURGICAL NEEDS YOU SHOULD CONSULT WITH YOUR PRIMARY CARE VETERINARIAN. IF YOUR PET IS HOSPITALIZED OVERNIGHT HE/SHE WILL BE UNDER THE CARE OF THE EMERGENCY CLINIC LOCATED IN OUR FACILITY, AND CHARGES MAY BE INCURRED.

ALL FEES ARE DUE UPON RELEASE OF YOUR PET. ANY MEDICATIONS, ANTIGENS, OR OTHER MEDICAL SUPPLIES MAILED TO YOU WILL BE BILLED SEPARATELY AND IN ADDITION TO APPOINTMENT CHARGES. WE ACCEPT CASH, PERSONAL CHECKS, MASTERCARD, VISA, AND DISCOVER.

WE ARE LEADERS AND TEACHERS IN THE FIELD OF VETERINARY DERMATOLOGY. MEDICAL FILES, THUS CASE INFORMATION AND/OR PHOTOS MAY BE USED IN TEACHING, FORMS, CONTINUING EDUCATION, WEBSITE, VETERINARY LITERATURE, AND THE LIKE. I AUTHORIZE THE RELEASE OF CASE/PATIENT INFORMATION FOR SUCH PURPOSES; CLIENT CONFIDENTIALITY (Names and Personal Information) WILL BE MAINTAINED.

I UNDERSTAND THAT NO GUARANTEE CAN BE MADE AS TO THE RESULTS OBTAINED FROM MEDICAL TREATMENT. FURTHER, I ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED BY THE PATIENT.

DATE \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE OF OWNER OR RESPONSIBLE AGENT**