WELCOME!

GRAYLING HOSPITAL FOR ANIMALS
AND
ROSCOMMON VETERINARY CLINIC
DR. FAIRBANKS ~ DR. MESACK ~ DR. POWNING

We thank you for choosing our health care team. Please complete the following information to help us provide your pet with quality care.

OWNER INFORMATION:

DR./MR./MS./MRS._____
LAST FIRST MIDDLE

MAILING ADDRESS:_____

_____
CITY STATE ZIP

E-MAIL_____ LOCAL NUMBER (IF NOT FULL TIME RESIDENT)_____

HOME PHONE _____WORK PHONE_____CELL PHONE_____

NAME OF HUSBAND/WIFE_____REFERRED BY_____

PLEASE LIST ANY OTHERS WITH WHOM WE ARE AUTHORIZED TO DISCUSS YOUR PET'S MEDICAL CONDITION

_____

PET INFORMATION:

PET'S NAME_____ DOG CAT OTHER (PLEASE CIRCLE)

BREED_____COLOR_____AGE OR DATE OF BIRTH_____

MALE / FEMALE (CIRCLE) IS YOUR PET SPAYED OR NEUTERED? YES / NO (CIRCLE)

HOW LONG HAVE YOU OWNED THIS PET? _____ WHERE DOES THIS PET SLEEP?_____

DATE OF LAST VACCINE AND OR TEST GIVEN_____

LAST VETERINARIAN WHO PROVIDED SERVICES FOR YOUR PET_____

ARE THERE ANY PREVIOUS MEDICAL PROBLEMS OR ALLERGIES OF WHICH WE SHOULD BE

AWARE?_____ PLEASE EXPLAIN_____

IS YOUR PET CURRENTLY ON ANY MEDICATIONS?_____

WHAT BRAND OF PET FOOD DO YOU CURRENTLY FEED?_____

DO YOU HAVE OTHER PETS? WHAT TYPE AND HOW MANY?_____

DUE TO THE NATURE OF THE SERVICES RENDERED IN THIS OFFICE, FULL PAYMENT IS REQUIRED WHEN SERVICES ARE RENDERED. A SUBSTANTIAL DEPOSIT IS REQUIRED ON HOSPITALIZED PATIENTS WHEN CHARGES OF $100 (ONE HUNDRED DOLLARS) OR MORE ARE INCURRED. PLEASE INDICATE BELOW YOUR CHOICE OF PAYMENT.

FORM OF PAYMENT

CASH_____ PERSONAL CHECK_____ VISA/MC/DISC_____CARE CREDIT_____