



The Kind Of Care Your Pets Deserve

Owner's Information:

Name: _____
Last First Middle

Address: _____
Street Apt No. City Zip code

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email Address: _____

Business Address: _____
Street Apt No. City Zip code

Spouse or CO-owner: _____

Emergency Contact: _____ Phone #: (_____) _____

Pet's Information:

Pet's Name: _____ Species: Dog Cat Other: _____

Age or DOB: _____ Gender: Male Female Color: _____

Breed: _____ Neutered/ Spayed No Yes, at what age? _____

Where did you obtain this pet? Friend Breeder Pet Shop Animal Shelter Other: _____

For what purpose was this pet obtained? Protection Companionship Breeding Show Other: _____

At what age was the pet obtained? _____ What kind of diet is the pet eating? _____

Pet's History (check all that the pet has received):

DA2P (distemper) vaccine

Corona virus vaccine

Parvovirus vaccine

Bordetella (Kennel Cough) vaccine

Heartworm test

FVRCP (feline distemper) vaccine

Feline leukemia vaccine

FELV/FIV test

FIP vaccine

Rabies vaccine

I hereby authorize The Pet Doctor of Flushing to examine, prescribe for, treat or perform surgery upon the above described pet. I also consent to the administration of such anesthetics as are necessary. Furthermore, I agree to pay fees for services rendered at the time my pet is discharged from the clinic or when service is otherwise terminated. The Pet Doctor of Flushing is authorized to humanely dispose of said animal unless I, the owner, or an authorized agent of mine, calls for and pays all accrued charged on the animal within ten (10) days after written or oral notification that the animal is ready to be released from the hospital. I further understand that veterinary service is not provided during nighttime hours. Continuous presence of qualified personnel may not be provided at all times.

Owner's signature: _____

Date: _____