Welcome to
Rockland Veterinary Care
At
North Rockland Animal Hospital

Thank you for giving us the opportunity to care for your pet. In order to serve you properly we will need the following information. (Please Print). All information will be strictly confidential.

Date: ___________

Owner: ____________________________ Spouse/ Co-Owner: ___________________

Address: ____
Street

____
City State Zip Code

Home Phone: ____________ Work Phone: ____________ Cell Phone: ___________

We will gladly prepare a written estimate if desired, just ask any staff member or doctor. PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE. If you will be paying by check or credit card, please complete the following information:

Driver's License Number: _____________________________________
(Our office accepts Visa, Mastercard, American Express, Discover, Checks and Cash)

*************************Patient Information**************************

Pet's Name: ___________________ Dog: ____ Cat: ____ Other: ____

Breed: ________________________ Color: ____________ Birthdate: ______________

Male: _____ Neutered: _____ Female: _____ Spayed: _____

Drug Allergies: No: ___ Yes: ___ If yes, please name drug(s): ___________________

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of my pet; I also understand that these charges will be paid at the time of release and that a deposit may be required for major medical and/or surgical procedures.

Signature of Owner or Responsible party: _______________________ Date: _______

TO PREVENT THE SPREAD OF INFECTIOUS DISEASE AND PARASITES, HOSPITILIZED PETS MUST BE CURRENT ON ALL VACCINES AND FREE OF INTERNAL AND EXTERNAL PARASITES.