

**Welcome to
Rockland Veterinary Care
At
Pomona 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,
HOSPITALIZED PETS MUST BE CURRENT ON ALL VACCINES AND FREE
OF INTERNAL AND EXTERNAL PARASITES.**
