



East Lohman Veterinary Clinic, LLC

Dr. Deborah L. Cook, D.V.M. Dr. Jamie Ross, D.V.M.



CLIENT INFORMATION

Primary Owner: _____ Phone #: _____

Occupation: _____ Employer: _____

Work Phone #: _____ *May we contact you via e-mail or text? Yes No

Email: _____

Co-Owner: _____ Phone #: _____

Occupation: _____ Employer: _____

Work Phone #: _____ May we contact you there? Yes No

Address: _____

City: _____ State: _____ Zip: _____

In addition to my self and the co-owner, I authorize the following individuals to seek medical treatment and receive updates for my pets, this includes, but is not limited medical treatment, surgery, radiographs, and ultrasounds. I will assume all financial responsibility for any costs that incurred during treatment.

Name: _____ Relationship to owner/co-owner: _____ Phone #: _____

In case of an emergency is this individual allowed to make end of life decisions: Yes No

Name: _____ Relationship to owner/co-owner: _____ Phone #: _____

In case of an emergency is this individual allowed to make end of life decisions: Yes No

Is there someone we can thank for a referral? _____

Number of pets in household. Dogs _____ Cats _____ Birds _____ Reptiles _____ Rabbits _____ Ferrets _____ Other _____

I will assume responsibility for all charges incurred in the care of my pets. I understand the FULL PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED and that a DEPOSIT IS REQUIRED FOR ANY HOSPITALIZED PET. Failure to pay on time may result in billing, finance charges, and/or costs of any collection fee incurred.

Signature: _____ Date: _____

PET INFORMATION

Name of Pet: _____ Species: _____ Date of Birth: _____

Gender: Female Male Spayed/Neutered? Yes No

Color: _____ Markings: _____

Is your pet on any medications (includes all over the counter medications and supplements)? If yes, please list:

PET INFORMATION:

Name of Pet: _____ Species: _____ Date of Birth: _____

Gender: Female Male Spayed/Neutered? Yes No

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PET INFORMATION:

Name of Pet: _____ Species: _____ Date of Birth: _____

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