Tavares Crossroads
VETERINARY CLINIC

Welcome To Tavares Crossroads Veterinary Clinic

Owner Information:

Your Name: _____ Spouse/Other: _____

(Mailing) Address: _____ City: _____ State: _____ Zip: _____

Mobile Phone: _____ Home Phone: _____

Email Address: _____ Pet Insurance: _____

How did you hear about our clinic? ☐ Internet ☐ Drive by/Sign ☐ Referral

Preferred Contact Method? ☐ Phone ☐ Email

Reason for your visit: _____

Pet's Current Medications: _____

Preventatives? (Ex: Heartworm, Flea & Tick) _____

Known allergies or allergic reactions? _____

Describe your pet's diet (Ex. brand of food, dry, canned?) _____

Patient Information (continue on back if needed)

Pet Name	Cat	Dog	Other	DOB or Age	Sex	Fixed	Breed	Color
					M or F	Y or N		
					M or F	Y or N		

Informed Consent

I hereby authorize the Tavares Crossroads Veterinary Clinic veterinarian(s) to examine, prescribe for and treat the above-described pet(s). I assume responsibility for all charges incurred in the care of this animal. I understand that these charges will be paid at the time of discharge and that a deposit may be required for necessary treatment and/or hospitalization.

_____ _____

Signature of Client **Date**

Tavares Crossroads Veterinary Clinic
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