**Primary Contact Information:** NOTE: Click with mouse to check mark any boxes.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Full Name:** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **Address:** *(if P.O. Box, also list physical address)* | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **City:** |  | | | | | | | | | | | | **State:** |  | | | **Zip Code:** | |  |
| **Email:** | |  | | | | | | | | | | | | | | | | | |
| **Cell Ph:** | | |  |  | | | **Home Ph:** | | | |  |  | | | **Work Ph:** | |  |  | |
| ***Check box for the phone number that we should consider the main/best number.*** | | | | | | | | | | | | | | | | | | | |
| **Primary** client’s driver license number: | | | | | | | |  | | | | | | | | *(required if paying by check or credit card)* | | | |
| **Primary** client’s birthdate: | | | | |  | / |  | | / |  | | | *(required to dispense certain medications, per federal regulation)* | | | | | | |

**Receiving Appointment Reminders:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Check (ONE) box to choose your preference |  | **Phone Call** |  | **Email** |  | **Text (**SMS**)** |

**Other Authorized Contact Information:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Full Name:** | | | | | | | | |
|  | | | | | | | | |
| **Email:** |  | | | | | | | |
| **Cell Ph:** |  |  | **Home Ph:** |  |  | **Work Ph:** |  |  |
| ***Check box for the phone number that we should consider this person’s main contact number.*** | | | | | | | | |

**Your Pet’s Information:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Name:** | | | | | | | | **Age or DOB:** | | | **Sex:** | | | **Spayed or Neutered?** | |
|  | | | | | | | |  | | |  | Male | |  | Yes |
|  | Female | |  | No |
| **Species:** | |  | Canine |  | Feline |  | Other, *if other specify:* | |  | | | | | | |
| **Breed:** |  | | | | | | | | | **Color:** | | |  | | |

**Your Pet’s Veterinarian Information:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Doctor Name:** | | | | | | |
|  | | | | | | |
| **Hospital Name:** | | | | | | |
|  | | | | | | |
| Are there any other veterinarians you would like us to update? | | | No | |  | If yes, please list their name and associated hospital below. |
| Yes | |  |
| **Doctor:** |  | **Hospital:** | |  | | |
| **Doctor:** |  | **Hospital:** | |  | | |

**How did you hear about Veterinary Cancer Group?**

*(please check boxes that apply)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Veterinarian** |  | **Relative/Friend** |
| Name: |  | Name (optional): |  |
|  | **Social Media** (Facebook, etc.) |  | **Internet/Website** |
| Specify: |  | Specify: |  |
|  | **Yelp** |  | **Other** |
|  |  | Specify: |  |

**Social Media:**

Do we have your permission to share pictures and stories of your pet on Veterinary Cancer Group’s social media pages? **(please check box)  YES  NO**

**The information given above is correct to the best of my knowledge, and I understand that I am responsible for the full payment of services at the time they are provided.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** |  | **Date:** |  |

*Typing in your name is acceptable for signing this document*

**Cancellation Policy:**

Please understand that when you forget your appointment or reschedule with minimal notice, we miss the opportunity to see other patients who need us. Because of this, we require 24 hours’ notice to reschedule appointments.