PetCare Veterinary Hospital & Referral Center

PETCARE
1370 Fulton Road Santa Rosa, CA 95401 (707) 579-5900 FAX # (707) 579-9512

Patient #:	Admission Time:	Admission Date:	*Regular Vet:*	Receptionist:	Nurse:

Name: (last, first)	*Home:*	*Work:*	*Cell:*

Address:	*City:*	*Zip Code:*

CA Drivers Lic. #:	Method of Payment:	Employer & Address:

Pets Name:	*Breed:*	*Color:*	*Sex:* M F	*Altered:* Y N	*Age or Date* of Birth:

I authorize the doctor to examine and evaluate my pet. A written estimate will be provided for suggested treatment based on the findings of the exam. In a life threatening emergency, treatment may be started prior to providing a written estimate. I assume financial responsibility for all treatments and services. All hospital fees are required to be **paid in full at the time services are performed**. A deposit may be required. I understand a billing fee will be applied to all accounts unpaid after 30 days, with a periodic rate of 1.50% per month or 18% APR, minimum charge of $2.00.

Client Signature _____

WT:	HR:	Resp:	MM:	CRT:	Temp:

	RDVM Phone:		DVM:	
	Faxed RDVM:	Meds TGH:	X-Rays In:	X-Rays Out: