Welcome to Mount Rose Animal Hospital

Last Name:_____ First Name: _____

Spouse Last Name:_____ First Name:_____

Street Address (Mailing):_____

City:_____ State:_____ Zip:_____

Cell Phone Number: (____)_____ Other Phone Number: (____)_____

Email Address:_____

Emergency Contact:_____ **Phone: (_____)**_____

Referred by: _____

Pet Information

Pet Name:_____ ▫ Dog ▫ Cat ▫ Other _____

Breed:_____ **Age:**_____ **Birthdate:**_____

Sex:_____ **Spayed/Neutered: ▫ Yes ▫ No Color:**_____

Describe your pet's diet:_____

List your pet's current medications:_____

_____

Please list the previous Veterinary Practices where this pet has been seen:_____

_____

_____

Additional Pet(s)

Pet Name:_____ ▫ Dog ▫ Cat ▫ Other _____

Breed:_____ **Age:**_____ **Birthdate:**_____

Sex:_____ **Spayed/Neutered: ▫ Yes ▫ No Color:**_____

Describe your pet's diet:_____

List your pet's current medications:_____

_____

Please list the previous Veterinary Practices where this pet has been seen:_____

_____

_____

Authorization

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet. I assume responsibility for all charges incurred in the care of the animal. I also understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

Signature:_____ Date:_____