



**MOUNT ROSE
ANIMAL HOSPITAL**

Welcome to Mount Rose Animal Hospital!

New Client Information

Last Name _____ First Name _____

Spouse Last Name _____ First Name _____

Street Address (Mailing) _____

City _____ State _____ Zip _____

Driver's License Number _____ Home Phone (____) ____-____

Cell/Other Phone (____) ____-____ Spouse Cell (____) ____-____

Employer _____ Occupation _____

Work Phone (____) ____-____ Spouse Work (____) ____-____

Email Address _____

Would you like to receive e-mails, including coupons and specials, from us? Yes No

Emergency Contact _____ Phone (____) ____-____

Referred from _____ * If you tell us whom you were referred from, we'll send them a \$10 off coupon for the next time they visit us!

Pet Information

Pet's Name _____ Dog Cat Other _____

Sex M F Age _____ Birthdate _____ Breed _____

Color _____ Neutered/Spayed? Yes No

Describe your pet's diet _____

List your pet's current medications _____

Additional Pet(s)

Pet's Name _____ Dog Cat Other _____

Sex M F Age _____ Birthdate _____ Breed _____

Color _____ Neutered/Spayed? Yes No

Describe you pet's diet _____

List your pet's current medications _____

Authorization

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet(s). 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 of client responsible for pet(s) _____ Date _____