



"For every paw, there is a pulse. For every heart, there is a beat. This is where the human-animal bond meets. "

Thank you for choosing and entrusting us with the care of your furry friend.
Please take a few moments to fill out this form so we can get to know you better.

CLIENT INFORMATION

PRIMARY OWNER'S NAME _____

ADDRESS _____ APT _____

CITY _____ STATE _____ ZIP CODE _____ COUNTY _____

HOME PHONE (_____) _____ - _____ CELL PHONE (_____) _____ - _____

DATE OF BIRTH _____ / _____ / _____ EMAIL ADDRESS _____

DL# _____ STATE OF DRIVERS LICENSE _____

EMPLOYER _____ OCCUPATION _____

WORK PHONE (_____) _____ - _____ EXTENSION _____

If necessary, may we contact you at work? YES NO

In the event that you cannot be reached by phone in a timely manner, who would you like us to contact to authorize treatment and the associated costs for the care of your pet?

EMERGENCY CONTACT _____

RELATION _____ PHONE (_____) _____ - _____

PET INFORMATION

PETS NAME _____ **BIRTHDATE** ____/____/____

SEX (MALE / FEMALE) **REPRODUCTIVE STATUS** (INTACT / SPAYED / NEUTERED)

SPECIES (CANINE / FELINE) **BREED** _____ **COLOR** _____

PRIMARY / PREVIOUS VETERINARIAN (Doctor, Hospital & Location) _____

PREVIOUS INJURIES / ILLNESSES / SURGERY _____

CURRENT MEDICATIONS _____

DOES YOUR PET HAVE ANY FEARS OR ANXIETIES? (Mark all that apply:) YES NO

Aversive to touch (face, ears, belly, feet, tail, etc) Fearful of new people Fearful of men

Does not like nail trims Afraid of muzzles Thunderstorm / Firework Phobia

Diagnosed an anxiety disorder (Type): _____

HOW DOES YOUR PET RESPOND WHEN FEARFUL OR ANXIOUS? (Mark all that apply:)

Bites Scratches Lunges Tucks tail Hides or Runs away Hisses

Howls/Screams Urinates/Defecates Freezes/Shakes Becomes Protective of Owner

NAME OF CURRENT PET FOOD (Name, Protein Source) _____

KNOWN ALLERGIES (Food, Medications, Insects, etc) _____

HAS YOUR PET EXPERIENCED A VACCINE REACTION? YES NO

If yes, which vaccine(s): _____

DATE OF LAST RABIES VACCINE ____/____/____ (CIRCLE ONE: 1 year vaccine / 3 year vaccine)

NAME OF CURRENT HEARTWORM PREVENTION _____

NAME OF CURRENT FLEA & TICK PREVENTION _____

MEDIA RELEASE AUTHORIZATION

I authorize The Advetcate, LLC to use, reproduce, and/or publish photographs and/or video that may pertain to my pet – including my pet’s image, likeness and/or sound without compensation. I understand that this material may be used in various publications, public affairs releases, recruitment materials, broadcast public service advertising (PSAs) or for other related endeavors. This material may also appear on The Advetcate’s Internet Web Page or its other social media sites. This authorization is continuous and may only be withdrawn by my specific rescission of this authorization. Consequently, The Advetcate, LLC may publish materials, use my pets’ name, photograph, and/or make reference to my pet(s) in any manner that The Advetcate, LLC deems appropriate in order to promote/publicize/educate service opportunities.

DECLINED _____ ACCEPTED _____

CLIENT AGREEMENT

I/we hereby authorize The Advetcate, LLC and all assistants of its choice to administer any medical and/or surgical procedures as is considered therapeutically and/or diagnostically necessary. I/we also hereby release The Advetcate, LLC and all its assistants, from any liability by any reason of any act herein above authorized. I understand every effort will be made to achieve a successful outcome and that The Advetcate, LLC and all of its assistants will perform all possible safety procedures while handling my pet(s).

PAYMENT TERMS: Our preferred methods of payment include: Debit and Credit cards (Visa, Mastercard, American Express, Discover). In signing this agreement, I assume full financial responsibility for all charges incurred for the care of my pet(s). I understand that payment for the entire medical plan is required when services are rendered, and if I fail to pay the entire amount at the time services are rendered, that I agree to pay any and all reasonable costs of collection in the event that collection efforts become necessary.

Signing below indicates that you are the owner or responsible party of the pet listed on this form, and that you have read, understood, and accept the client agreement and payment terms listed above.

Printed Name of Owner / Responsible Party _____

Signature X _____ **Date** ____ / ____ / ____

Printed Name of Owner / Responsible Party _____

Signature X _____ **Date** ____ / ____ / ____

"Healing is Healthy"

**Don't forget to send the 'purrfect' picture of your furry friend for our records.
Send pictures to TheAdvetcate@gmail.com with your pets name in the subject line
(Example: "Pluto's Photoshoot").**

CREDIT CARD AUTHORIZATION AND PAYMENT TERMS

PAYMENT TERMS: Our preferred methods of payment include: Debit and Credit cards (Visa, Mastercard, American Express, Discover). In signing the Credit Card Authorization form below, I understand that payment for the entire medical plan is required when services are rendered. I further understand that if I fail to pay the entire amount at the time services are rendered, that I agree to pay any and all reasonable costs of collection in the event that collection efforts become necessary.

I _____, authorize The Advetcate, LLC to charge the credit card indicated on this authorization form according to the terms outlined above. This payment authorization is for the good/services provided today, for amount indicated on the invoice provided by The Advetcate, LLC. It is valid for one (1) time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated on this form.

CREDIT CARD TYPE: VISA MASTERCARD AMERICAN EXPRESS DISCOVER CARD

CARD HOLDER NAME (EXACTLY AS PRINTED ON CARD): _____

NUMBER: _____ **EXPIRATION DATE:** ____ / ____

SECURITY CODE / CVV NUMBER _____

SIGNATURE _____ **DATE:** ____ / ____ / ____