WELCOME

Thank you for giving MVS the opportunity to care for your pet. Our goal is to utilize the exceptional skills of our doctors, combined with the most advanced diagnostic tools, treatments and surgical options, to ensure your pet receives the best care possible. To help us provide effective service, please complete the following information:

OWNER NAME: ______________________

Address: ______________________

Patient ID#__________
Male ☐ Female ☐

City: ______________________

State: __________ Zip: __________

E-Mail: ______________________

Employer: ______________________

Work Address: ______________________

Would you like to receive our pet health e-newsletter? Yes ☐ No ☐

Home Ph: ______________________

Cell/Pager: ______________________

Work Ph: ______________________

SIGNIFICANT OTHER: ______________________

Employer of Significant Other: ______________________

Significant Other Ph: ______________________

Significant Other Work Ph: ______________________

Significant Other Cell/Pager: ______________________

PET NAME: ______________ Dog ☐ Cat ☐ Breed: ______________ Color: __________

Date of Birth/Age: __________ Male ☐ Female ☐ Spayed/Neutered ☐ Intact ☐ Weight: ______

Drug Allergies/Reactions: ______________________

PRIMARY CARE VETERINARIAN

Clinic Name: ______________ Doctor Name: ______________ Phone: ______________

Clinic Name: ______________ Doctor Name: ______________ Phone: ______________

• PAYMENT IN FULL IS EXPECTED WHEN SERVICES ARE RENDERED •

(Michigan Veterinary Specialists does not offer billing or payment plan options.)

Cash ☐ Personal Check ☐ VISA ☐ MasterCard ☐ Am.Express ☐ Discover ☐ CareCredit ☐

Driver's License Number: ______________________ Birthdate: ______________________

Release: I am the owner of the above pet, or am acting as the agent for the owner, and accept full financial responsibility. I give permission to proceed for any medical and/or surgical therapy as discussed and needed and agreed upon with the doctor(s). I give permission to release my pet's medical information to my referring or primary veterinarian(s).

SIGNATURE: ______________________ **DATE:** ______________

FOR OFFICE USE ONLY
AFFIX LABEL

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AFFIX LABEL

FOR OFFICE USE ONLY

X-Rays: Y ☐ N ☐ **D-Rays:** Y ☐ N ☐

NOTES:

ACTIVE DATE	#	MASTER PROBLEM LIST	RESOLVED DATE

Client:	Pet:	ID#:

ACTIVE DATE	#	MASTER PROBLEM LIST	RESOLVED DATE