Veterinary Services, Ltd.
8500 Old US Hwy 50
Breese, IL 62230
(618)526-7851 (618)526-2283 Fax (618)526-2007

Thank you for giving us the opportunity to care for your pet. Please help us meet your needs better by taking a moment to share some important information we will need as we support your pet's needs today and in the future. **PLEASE PRINT IN ALL SPACES.**

PRIMARY OWNER'S NAME_____

PRIMARY'S PHONE NUMBER_____

PRIMARY'S E-MAIL_____

SPOUSE OR CO-OWNER'S NAME_____

SECONDARY'S PHONE NUMBER_____

ADDRESS_____CITY_____

STATE_____ ZIP CODE_____ COUNTY_____

PREFERRED COMMUNICATION METHOD FOR AUTOMATED REMINDERS: (CHOOSE ONE)

☐ Text
☐ Email
☐ Phone

HOW DID YOU HEAR ABOUT OUR CLINIC?

☐ Facebook ☐ Webpage ☐ Drive-by ☐ Hometown Phonebook
☐ Internet ☐ I/we was a previous client

☐ Referral (Please provide a name so we know who to thank.)
_____

Full payment for all services and products is due at time of dispensing. We accept MasterCard, Visa, Discover, American Express, cash, or personal check. We do not carry charge accounts. There will be a $30.00 service charge for any check returned.

How do you intend to pay for this service?

_____Cash _____MasterCard _____Visa _____Discover _____American Express _____Check

PET INFORMATION

(Please fill in the following for each pet)

NAME				
SPECIES (Cat, Dog, Other)				
BREED				
COLOR				
DATE OF BIRTH				
SEX				
ALTERED? (spayed/neutered)				
PRE-EXISTING CONDITIONS				
ALLERGIES (MEDS, VX, ETC.)				
CURRENT MEDICATIONS				

PREVIOUS VETERINARIAN'S INFORMATION:

NAME_____

PHONE NUMBER_____

The law mandates that we obtain your written permission before releasing records to boarding kennels, groomers, and other veterinarians. Please check ***ONE*** box below.

[] Please obtain my written permission each time medical records are requested.

[] This signature represents my written permission to release medical records when requested by boarding kennels, groomers, and other veterinarians.

Owner's signature: _____Date: _____