



Michigan Veterinary SpecialistsSM

www.michvet.com

We Can Help

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: _____

Patient ID# _____
Male <input type="checkbox"/> Female <input type="checkbox"/>

Address: _____

City: _____

May we contact you with pet health information & news? Yes No

State: _____ Zip: _____

E-Mail: _____

Home Ph: _____

Employer: _____

Cell/Pager: _____

Work Address: _____

Work Ph: _____

SIGNIFICANT OTHER: _____

Significant Other Ph: _____

Employer of Significant Other: _____

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: _____

FOR OFFICE USE ONLY
AFFIX LABEL

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• 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

X-Rays: Y N D-Rays: Y N

NOTES:

ACTIVE DATE	#	MASTER PROBLEM LIST	RESOLVED DATE

