



Animal Medical & Surgical Center

NORTH SCOTTSDALE

Hospital Member



Accredited by
the American
Animal Hospital
Association

17477 N. 82ND Street
Scottsdale, AZ 85255
480-502-4400

CLIENT INFORMATION

OWNER'S FULL NAME		SPOUSE/OTHER FULL NAME (IF APPLICABLE)	
HOME ADDRESS		CITY	ZIP
E-MAIL ADDRESS (FOR HOSPITAL USE ONLY)		HOME PHONE	
EMPLOYER'S NAME	ADDRESS	CITY	ZIP
SPOUSE'S/OTHERS EMPLOYER (IF APPLICABLE) ADDRESS		CITY	ZIP
BUSINESS PHONE		BUSINESS PHONE	
HOW WERE YOU REFERRED TO OUR HOSPITAL?		<input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> HOSPITAL SIGN	
<input type="checkbox"/> INDIVIDUAL NAME _____		<input type="checkbox"/> OTHER _____	

PATIENT INFORMATION (1st PET)

PET'S NAME		DATE OF BIRTH		<input type="checkbox"/> DOG	BREED
		MO. _____	YR. _____	<input type="checkbox"/> CAT	
<input type="checkbox"/> MALE	SPAYED OR NEUTERED	COLOR	WEIGHT	DATE OF LAST VACCINATION	
<input type="checkbox"/> FEMALE	<input type="checkbox"/> YES <input type="checkbox"/> NO		_____ LBS	DOG: DHLPP/CVK _____	CAT: FVRCP _____
				RABIES _____	RABIES _____
				CPV/CVK _____	LEUKEMIA _____
				Bordetella _____	

PATIENT INFORMATION (2nd PET)

PET'S NAME		DATE OF BIRTH		<input type="checkbox"/> DOG	BREED
		MO. _____	YR. _____	<input type="checkbox"/> CAT	
<input type="checkbox"/> MALE	SPAYED OR NEUTERED	COLOR	WEIGHT	DATE OF LAST VACCINATION	
<input type="checkbox"/> FEMALE	<input type="checkbox"/> YES <input type="checkbox"/> NO		_____ LBS	DOG: DHLPP/CVK _____	CAT: FVRCP _____
				RABIES _____	RABIES _____
				CPV/CVK _____	LEUKEMIA _____
				Bordetella _____	

(Please use second form for more than 2 pets)

To insure proper medical care for your pet(s), and for your convenience, Animal Medical and Surgical Center will enter your pets in our Computerized Recall System which will automatically mail you a reminder card at the appropriate time for all necessary vaccinations and exams. Please notify us of any address and/or phone changes.

FINANCIAL POLICY: Animal Medical and Surgical Center, requires payment in full for professional services rendered at the time of discharge from the hospital. As legal owner or responsible agent of the above pet(s) I certify that I have read and agree to the above financial policy. I hereby assume financial responsibility for all services rendered.

Please indicate method of payment: Cash _____ Debit Card _____ Visa _____ Mastercard _____
Discover _____ American Express _____ Care Credit _____

Signature of Owner or Agent

Date