Bayshore Animal Hospital & Avian Practice
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Dr. Christopher Learning
Dr. Steven Sanders
Dr. Kate Maitre

WELCOME TO BAYSHORE ANIMAL HOSPITAL & AVIAN PRACTICE

The doctors and staff would like to thank you for giving us the opportunity to care for your pets. To ensure the best care possible, please take the time to fill out this form completely.

Please email or fax all records to us <u>prior</u> to your appointment. THANK YOU!

Owner Information

First Name:	Last Name:	Spouse's Name:
Address:	City:	State: Zip:
Primary Cell:	Secondary Cell:	Home:
Email Address(es):		

Pet Information

Pet Name:	☐ DOG ☐ CAT ☐ BIRD ☐ OTHER ____________________	☐ MALE ☐ FEMALE ☐ NEUTERED / SPAYED
Breed:	Color:	DOB/Age:
Previous Vet Clinic (Name & Telephone Number):		

Please list any important medical information, medications, or diagnoses that will assist in the best care of your pet.

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Breed:	Color:	DOB/Age:
Previous Vet Clinic (Name & Telephone Number):		

Please list any important medical information, medications, or diagnoses that will assist in the best care of your pet.

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I hereby authorize the veterinarian to examine, prescribe for, or treat the following pet(s). I assume complete responsibility for all charges incurred in the care of this animal(s) during this and any future visits. I also understand that these charges will be paid at the time services are rendered and that a deposit may be required. I understand that any returned checks will be assessed a returned check fee and the face value of the check and the fee are collected by a third party. I also understand that should my account ever be turned over to a collection agency due to non-payment a collection fee may be added to my account.

Signature of Owner ____ Date ____________________