Rose Veterinary Hospital

1910 High Street, Canon City, CO 81212

Client Information:

Client Name: ______________________________

Spouse or Co-Owner: ______________________________

Address: ______________________________

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City: ______________________________

State: __________ Zip Code: ______________

Phones: Home ( ) ______________ Cell 1 ( ) ______________ Name __________

Work ( ) ______________ Cell 2 ( ) ______________ Name __________

Please indicate which phone we should use as your primary contact number by circling it.

E Mail Address: ______________________________

Patient Information:

Patient Name:		Patient Name:	
Registration #:		Registration #:	
Microchip #:		Microchip #:	
Age or DOB:		Age or DOB:	
Sex:		Sex:	
Spayed/Neutered (Castrated)	Yes No	Spayed/Neutered (Castrated)	Yes No
Breed:		Breed:	
Color (s):		Color (s):	

Patient Name:		Patient Name:	
Registration #:		Registration #:	
Microchip #:		Microchip #:	
Age or DOB:		Age or DOB:	
Sex:		Sex:	
Spayed/Neutered (Castrated)	Yes No	Spayed/Neutered (Castrated)	Yes No
Breed:		Breed:	
Color (s):		Color (s):	

I ____________________________________ hereby assume full and complete responsibility for the charges that are incurred

Print Name

during the examination and/or treatment of my animal. I also understand that there is no billing, no held checks, and that payment is due in full on completion of all necessary treatments and/or discharge of the patient. Furthermore, I do understand that if my animal is ill and/or hospitalized, a deposit may be required prior to the beginning of any necessary treatment.

Signature:____ Date:_______________________

WE ACCEPT CASH, MONEY ORDERS, PERSONAL CHECKS (WITH VALID DRIVERS LICENSE OR STATE ID), DEBIT CARDS, CREDIT CARDS (VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER), AND CARE CREDIT.

FULL PAYMENT OF ALL CHARGES IS DUE WHEN SERVICES ARE COMPLETE.