



3700 Riverview Rd. Riverton, WY * 307.856.7764 * www.rivertonvet.com

WELCOME TO OUR CLINIC

Thank you for giving us the opportunity to care for your pet. We are happy to answer any questions you have about your pet's health. To ensure the best care possible, please take the time to fill in this form completely. Thank you!

Owner's Date of Birth: _____ **Owner's Social Security Number** _____

Owner Name: _____
(Dr., Miss, Mrs., Mr.) First, Last

Spouse/Co-Owner Name: _____
(Dr., Miss, Mrs., Mr.) First, Last

Email Address: _____

Mailing Address: _____

Physical Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Co-Owner Cell:** _____

Employer's Name: _____ **Work Phone:** _____

Co-Owner Employer's Name: _____ **Work Phone:** _____

Emergency Contact Name: _____ **Phone:** _____

If recommended by someone, who may we thank? _____

AUTHORIZATION TO TREAT

BY SIGNING BELOW I UNDERSTAND AND AGREE TO: AUTHORIZE THE VETERINARIAN(S) TO EXAMINE, PRESCRIBE FOR, AND PROVIDE INITIAL DIAGNOSTICS FOR MY PET. I AM AWARE A DEPOSIT MAY BE REQUIRED PRIOR TO WORK UP. I AM 18 YEARS OLD OR OLDER AND AM ACCEPTING FINANCIAL RESPONSIBILITY FOR THIS PATIENT. I ASSUME FINANCIAL RESPONSIBILITY FOR ALL HOSPITAL CHARGES. I ASSUME RESPONSIBILITY FOR ALL FEES ASSOCIATED WITH THE COLLECTION OF ANY UNPAID BALANCES INCLUDING \$25.00 FOR RETURNED CHECKS. THE BALANCE WILL BE PAID IN FULL AT THE TIME OF DISCHARGE. A 1.5% FINANCE FEE WILL BE CHARGED EVERY 30 DAYS TO PAST DUE ACCOUNTS. SHOULD WE HAVE TO FILE SUIT IN ANY COURT OF LAW TO COLLECT THE AMOUNT DUE, I AGREE TO PAY ALL ATTORNEY FEES AND COURT COSTS INCURRED IN ANY COLLECTION EFFORT FOR MY ACCOUNT. I ASSUME RESPONSIBILITY OF A NO SHOW FEE OF \$50 IF I DO NOT CANCEL 24 HOURS BEFORE MY APPOINTMENT.

SIGNATURE OF OWNER/AGENT _____ **DATE:** _____

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If you accept these terms, please submit this form.

If you do NOT give such permission to The Stock Doc, please check this box and sign.

I DO NOT CONSENT TO THE ABOVE.

Signature: _____