Welcome to
Live Oak Animal Hospital

"Where your pet is part of our family, too."

Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐

Owner's First and Last Name: ____

Address: ____

City:______________________________ State: _________ Zip Code: ____________

Home Phone # (with area code):____

Cell Phone # (with area code): ____

Work Phone # (with area code): ____

Email Address:____

Social Security # (REQUIRED)____

Employer/Occupation ____

Spouse/Co-Owner's First and Last Name: _____________________________________

Spouse's Cell Phone #____

Whom may we thank for referring you to us?___________________________________

Pet Information
Pet #1

Name:____

Type of Pet: ☐ Dog ☐ Cat ☐ Other

Breed: ____

Color: ____

Sex: _____ Spayed / Neutered: Yes ☐ No ☐ Age:________ DOB:_____________

Are the vaccines current? Yes ☐ Date Given _____________ No ☐ Not Sure ☐

Vaccines Given By: ________________________ May we contact them? Yes ☐ No ☐

(Please continue to the next page)

Pet Information
Pet #2

Name:____

Type of Pet: ☐ Dog ☐ Cat ☐ Other

Breed: ____

Color: ____

Sex: ____ Spayed / Neutered Yes ☐ No ☐ Age:_______ DOB:____________

Are the vaccines current? Yes ☐ Date Given _____________ No ☐ Not Sure ☐

Vaccines Given By: _________________________ May we contact them? Yes ☐ No ☐

Pet Information
Pet #3

Name:____

Type of Pet: ☐ Dog ☐ Cat ☐ Other

Breed: ____

Color: ____

Sex: ______ Spayed / Neutered: Yes ☐ No ☐ Age: _________ DOB:____________

Are the vaccines current? Yes ☐ Date Given _____________ No ☐ Not Sure ☐

Vaccines Given By: _________________________ May we contact them? Yes ☐ No ☐

Pet Information
Pet #4

Name:____

Type of Pet: ☐ Dog ☐ Cat ☐ Other

Breed: ____

Color: ____

Sex: ______ Spayed / Neutered Yes ☐ No ☐ Age:______ DOB:_______________

Are the vaccines current? Yes ☐ Date Given _____________ No ☐ Not Sure ☐

Vaccines Given By: _________________________ May we contact them? Yes ☐ No ☐

(Please continue to the next page)

PAYMENT IS DUE IN FULL AT THE TIME SERVICES ARE RENDERED

I assume financial responsibility for ALL charges incurred in the treatment of animals listed above and any new additional pets added to my account.

Initial __________

I authorize the release of pertinent medical history and treatment information of my pets as deemed necessary to my family members or agents acting on my behalf.

Initial __________

I understand that if I do not pay this account as agreed, the account is subject to costs of collection, attorney fees, and including interest (any balance that is carried over a period of 30 days will accrue a monthly finance charge of 1.5% or a minimum of $2.50). I understand the "Return Check Fee" is $40.00.

Initial __________

We DO NOT provide in house financing. If you are unable to pay in full, please alert the receptionist immediately so that a Care Credit Application may be provided for financing.

I understand that the hospital staff will provide an estimate of current and anticipated charges any time I request one. I am requesting that veterinary care be provided for pets presented by me or my agents. I understand that I am financially responsible for all services provided. By submitting this form I agree to the payment terms above.

WE ACCEPT THE FOLLOWING: CASH, CHECK, MASTER CARD, VISA, DISCOVER, AMERICAN EXPRESS, AND CARE CREDIT.

Signature____**Date**____________________