



**Veterinary
Specialty
Center**

advanced care and rehabilitation

Client Registration

Dr. Darien Lawrence, BVSc, MS, Diplomate
ACVS, CCRT

Dr. Tammi Ruddle, DVM, Diplomate ACVS



Welcome. Thank you for giving the VSC surgery team the opportunity to care for your pet. Our goal is to utilize the exceptional skills of our doctors and staff, combined with the most advanced diagnostic tools, treatments and surgical options to ensure your pet receives the best possible care. To help us provide effective service, please complete the following information. We appreciate the confidence you have in the surgery and rehabilitation departments!

Owner Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Home Ph:** _____

Employer: _____ **Cell Ph:** _____

Work Ph: _____

Significant Other: _____ **Cell Ph:** _____

Work Ph: _____

Have you ever been here before? Yes No

Was it with the same pet? Yes No

Patient Information

Pets Name: _____ **Dog** **Cat** **Breed:** _____ **Color:** _____

Age: _____ **Sex:** _____ **Spayed/Neutered** **Intact** **Weight:** _____

Drug Allergies/Reactions: _____

Date of last Vaccinations: _____

Reason for Todays visit: _____

Family Veterinarian: _____

PAYMENT IN FULL IS REQUIRED WHEN SERVICES ARE RENDERED. METHODS OF PAYMENT INCLUDE: CASH, CHECK, MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER, CARE CREDIT AND PAYMENTBANC. If paying by check, you must provide a valid drivers license and social security card.

Authorization: I am the owner of the above pet, or am acting as an agent for the owner, I accept full financial responsibility for professional and clinic fees. I give permission to release my pet's medical information to my referring or primary veterinarian.

Signature of owner: _____ **Date:** _____