



Welcome



The Animal Medical Center of Warrenton would like to thank you for choosing us to care for your pet!
Please complete this form in its entirety so that we may provide the highest level of care for your pet.

OWNER INFO:

Last Name: _____ First Name: _____ Preferred Title: _____

Spouse or Co-Owner Name: _____ County of Residence: _____

Address: _____

Home#: _____ Work#: _____ Cell#: _____

Alt. Emergency Name and Number: _____

Driver's License Number: _____ Employer Name: _____

How did you hear about us? _____

PET #1 INFO:

Pet Name: _____ Date of Birth / Approx. Age: _____

Canine/Feline/Other species _____ Breed: _____

Sex: _____ Altered: _____ Color: _____

Permanent ID (Tattoo or Chip) _____ Allergies: _____

Significant Medical History: _____

PET #2 INFO:

Pet Name: _____ Date of Birth / Approx. Age: _____

Canine/Feline/Other species _____ Breed: _____

Sex: _____ Altered: _____ Color: _____

Permanent ID (Tattoo or Chip) _____ Allergies: _____

Significant Medical History: _____

AUTHORIZATION: I hereby authorize The Animal Medical Center of Warrenton and the Veterinarians on staff to examine, prescribe for, and/or treat my pet(s). I assume responsibility for all charges incurred in the care of my pets. I understand that these charges must be paid in full at the time of release and that a deposit may be required for emergency or surgical treatment.

Signature of Owner/Agent: _____ Date: _____