Full Circle
Veterinary Care

Welcome

We know your pet's health is important and we thank you for trusting us to care for them. To help us provide the best care possible, please take a few moments to fill out this form completely. Thank You!

Client(s)

Primary Parent: _____ Primary Parent Phone: _____

Email: _____

Secondary Parent: _____ Secondary Parent Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Pet Sitter Name: _____ Phone: _____

How did you learn about our clinic? ☐ Website ☐ Facebook ☐ Yelp ☐ Drive By ☐ Pet Event

If recommended, by whom? _____

Initials **Please initial each statement below as acceptance and acknowledgement**

_____ I authorize Full Circle Veterinary Care to call and obtain any/all previous medical records for my pet(s).
_____ I agree to keep my pet(s) contained or leashed while in common areas of Full Circle Veterinary Care.
_____ I understand that all charges for treatments and services are due in full the day of service/treatment.
_____ I understand that all appointment cancellations must be made at least 24hours in advance. Canceling less than 24hr prior or not showing up for an appointment may result in an appointment cancelation fee.
I understand that no one but myself or the other pet parent (owner) listed (if any) can make medical decisions or authorize treatments for my pet. If I am unable to bring my pet in for any reason and would like to authorize someone else to make medical decisions I will contact Full Circle Veterinary Care before hand to approve that individual(s).
_____ I understand that by law Oregon requires all pets to be vaccinated for Rabies. By acknowledging this statement, I agree to take full responsibility of any legal actions or consequences assigned to me if I choose not to vaccinate my pet for Rabies.
_____ I understand that Full Circle Veterinary Care does not accept returns of any preventive care medications or prescription drugs once they leave the hospital.
_____ I understand that VetSource is the only online pharmaceutical company that Full Circle Veterinary Care directly works with. If I choose to use any other online pharmacy I understand that the products obtained may not be guaranteed by the manufacturer.
_____ Access To Vetcove Online Pharmacy: www.fullcirclevets.com **Click:** *OUR ONLINE PHARMACY*

Our Mission: We are committed to delivering a full circle of care through excellence in personalized patient care and customer service.

I have read, fully understand and agree to the statements above.

Signature of Owner: _____ **Date:** _____

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Patient(s)

Name: _____ Species: ☐ Canine ☐ Feline ☐ Other: _____

Breed: _____ Color: _____ Birthdate: _____

Sex: _____ Neutered/Spayed: ☐ Yes ☐ No ☐ Unsure

Can we use your pets photo on social media sites? ☐ Yes ☐ No

Please check the box that best describes your pet's recent activity

Is your pet? ☐ **INDOOR** ☐ **OUTDOOR** ☐ **BOTH**

Please check yes or no to the following questions (use back side of page to elaborate, if needed)	YES	NO
Is your pet current on all vaccines?		
Has your pet ever had a reaction/side effect from a vaccine? If yes, please list medications.		
Has your CAT been tested for FELV/FIV within the last year?		
Are there other pets in your household? (if yes, how many? _____)		
Is your pet CURRENTLY receiving medication for flea/tick/heartworm prevention?		
Does your pet have access to table scraps/meat bones/raw meat? (if yes, where?_____)		
Has your pet traveled outside of the Pacific Northwest? (if yes, where?_____)		
Has your pet ever had a seizure? (If yes, how often? _____)		

Previous Clinic(s) you have visited with your pet: _____

How long have you had your pet? _____

What medications and/or supplements is your pet currently taking? _____

_____

What food is your pet currently eating? _____

Please list any previous medical or surgical problems:

Patient(s)

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet. I assume full responsibility for all charges incurred for the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required dependent on treatment costs.

Signature of Owner: _____ **Date:** _____