

 $1001~W.~15^{th}~Street~~Edmond,~OK~73013~~405.348.6580~~www.pmcofedmond.com$

New Client Information	
Name	Date
NameLast	First
Address	
CityState	
Cell phone	_ Other phone
Employer	
Occupation	Work number
Spouse or co-owner	Phone
Email addragg	
Driver's License #	Would you like text/e-mail communications? Yes No
Whom may we thank for referring you to	our practice?
	Pet #1
Dot's name	
Ago/Rinthday	
Color Neutered/Spayed	Yes No At what age?
	eder Pet Shop Humane Society Other
where did you obtain this pet: Friend	eder
	Pet #2
Pet's name	
Age/Birthday	Sex Female Male Breed
	☐ Yes ☐ No At what age?
	eder Pet Shop Humane Society Other
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	Payment
We will gladly prepare a treatment plan of se	rvice fees if you desire (please ask one of our team members).
full payment may be difficult at discharge, we accept charge for any check returned unpaid. To prevent th	rendered. In cases of extensive medical or surgical procedures where major credit cards or Care Credit. There will be a \$25.00 service e spread of infectious diseases, all hospitalized patients must be ternal parasites. The signature below authorizes this level of e assessed in the discharge invoice.
Signature of client responsible for pet(s)	Date
Author	rized Care Givers
authorized to allow treatment, sign treatment plans a your pet(s), we will not allow anyone unauthorized b	
Authorized Individuals:	

Social Media Consent