DORAL WELFARE ANIMAL CLINIC

WELCOME

Welcome to DWAC. Thank you for giving us the opportunity to care for your pet. We will be happy to answer any questions you may have about your pet's health. Here at DWAC our mission is to provide your best friend with our very best loving, compassionate veterinary health and wellness care from before hello to beyond good-bye. To ensure the best care possible, please take the time to fill out this form.

NOTE: DO NOT OPEN FILES FOR MINORS. NO ABRIR EXPEDIENTES A MENORES DE EDAD.

OWNER/DUEÑO _____
LAST NAME-(APELLIDO) **FIRST NAME – (NOMBRE)** **MIDDLE NAME**

ADDRESS/ DIRECCION_____
CITY/STATE **ZIP CODE**

PHONE _____ **EMERGENCY PHONE** _____

SPOUSE or CO-Owner's NAME _____ **PHONE** _____

REFERED BY _____

Only for the clinic purposes: EMAIL ADDRESS _____

Please check here if you give us permission to put your pet's pictures on our Facebook. YES ___ NO___

PET No 1

NAME/NOMBRE _____

MICROCHIP # _____

BIRTH DATE _____

CAT _____ **DOG** _____ **SEX** _____

BREED/RAZA _____

COLOR _____

NEUTERED?/ CASTRADO _____

LAST DATE VACCINATION _____

LAST DATE RABIES _____

WHERE SHOTS OBTAINED? _____

ALLERGIES
LONG TERM PROBLEMS_____

MEDICATIONS_____

PET No 2

NAME/NOMBRE _____

MICROCHIP # _____

BIRTH DATE _____

CAT_____ **DOG** _____ **SEX** _____

BREED/RAZA _____

COLOR _____

NEUTERED? / CASTRADO _____

LAST DATE VACCINATION _____

LAST DATE RABIES _____

WHERE SHOTS OBTAINED? _____

ALLERGIES
LONG TERM PROBLEMS_____

MEDICATIONS_____

REASON FOR CALL: EXAM_____ **DIARREAH**_____ **COUGHING**_____ **SNEEZING**_____ **EATING PROBLEM**_____

VOMITING_____ **OTHER**_____

I hereby authorize the veterinarian and his/her assistants to examine, prescribe for, or treat, the above described pet (s). I assume responsibility for all charges incurred in the care of this animal. The nature of such services has been described to me, to my satisfaction, and while I expect all procedures to be done to the best abilities of the professional staff. I realize that there is no guarantee or warranty that can be ethically or professionally made regarding the results or cure. I understand that I will not receive a refund on any type of medication/and or vitamins. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment. I understand that Doral Welfare Animal Clinic may be not present overnight; only during office hours.

SIGNATURE OF OWNER or AGENT _____ **DATE** _____