Veterinary Associates

Brandon Landry, DVM
Caroline Landry, DVM, dip ACVIM

Sarah Bridgmon, DVM
Scott Busby, DVM
Carolyn Crochet, DVM

Date / /	Client Last Name	First Name	MI	Appt. time:
				Client Information

Client Address	City	State	Zip	Service Code

Home Phone	Alt. Phone

Client E-mail Address (for rebates)

Pet Name	□ Dog □ Cat □ _____	Age	Sex

Breed	Color

Reason for appointment:

History:

Physical Examination: N = Normal, A = Abnormal

1. General Appearance _____	4. Eyes _____	7. Ears _____	10. Respiratory _____	13. Nervous ____
2. Hydration _____	5. Nose _____	8. Integument _____	11. Abdominal _____	14. Musculoskeletal ____
3. Mucous Membranes _____	6. Mouth _____	9. Lymph Nodes _____	12. Circulatory _____	15. Urogenital _____

Temp:	Pulse:	H.R.:	Resp:	Wt:	Prev. Wt:

Dr. Comments:

AUTHORIZATION FOR TREATMENT – PLEASE READ AND SIGN.

- I authorize Veterinary Associates to treat the above described animal and agree that I am said animal's agent/responsible party.
- I understand that treatment may include, but is not limited to, vaccinations, injections, anesthesia, surgery, medications and any other procedures the doctor recommends.
- I understand that no guarantee of successful treatment is made and will not hold Veterinary Associates responsible for my animal's recovery.
- I understand Veterinary Associates is NOT staffed to provide 24-hour care nor overnight care.
- I understand that the doctors and support staff make every attempt to ensure all charges are invoiced at the time of service. However, if a mistake is made or a charge is missed, I understand that I will be invoiced and payment will be expected within 30 days of billing.
  I AGREE TO PAY ALL CHARGES INCURRED AT THE TIME OF RELEASE OF MY ANIMAL BY CASH, CHECK (with proper I.D.), Master Card, VISA, or DISCOVER.

My signature below indicates that I have read and agree to all of the above conditions.

Signature _____ Date: _____