ROCK RIVER Animal Clinic

Welcome to Rock River Animal Clinic

Owner Information

Name: _____ Secondary Contact Name: _____

Address: _____ City: _____State: _____ Zip Code: _____

Mobile Phone: _____ Secondary Mobile Phone: _____

E-mail: _____

Patient Information

Pet Name	Cat/Dog	DOB/Age	Sex	Spay/Neuter	Breed	Color
			M/F	Y/N		
			M/F	Y/N		
			M/F	Y/N		

Cancellation Policy

I hereby understand Rock River Animal Clinic's cancellation policy. All appointments, including Technician visit, MUST be cancelled or rescheduled no less than 24 hours prior to scheduled appointment. All late cancellations and no shows are subject to a $35.00 fee.

_____ _____

Client Signature Date

Informed Consent

I hereby authorize the Rock River Animal Clinic veterinarian(s) to examine, prescribe for, and treat the above-described pet(s). I assume full responsibility for all charges incurred in the care of this animal. I understand that these charges will be paid at the time of discharge, and that a deposit may be required for necessary treatment and/or hospitalization.

_____ _____

Client Signature Date

How did you hear about us?

___Search Engine ___Local Ad/Flyer ___Other: _____

___Social Media ___Friend/ Family: Referral Name_____

ROCK RIVER ANIMAL CLINIC
601 Madison Avenue
Fort Atkinson, WI 53538