# Welcome ROXBURY ANIMAL CLINIC

## Client Information

### Personal Information

Full Name: _____
*Last* *First* *M.I.*

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *ZIP Code*

Primary Phone: _____ Alternate Phone: _____

Email _____

Birth Date: _____
*Date of birth is required for any controlled drugs prescribed by our doctors

Driver License #: _____ Date issued: _____

Spouse/Partner Name: _____

### Emergency Contact Information

Full Name: _____
*Last* *First* *M.I.*

Cell Phone: _____ Alternate Phone: _____

Relationship: _____

Do we have permission to use your cell phone for text purposes? Yes No

### Method of Contact and Payment

Preferred method of contact: ____ Email ____ Text _____ Cell Phone

How will you be paying for service today: _____ Cash _____ Check _____ Credit Card

Would you like us to hold a credit card on file? YES NO

### Veterinary Client Patient Relationship

I hereby consent to a veterinary client relationship (VCPR), mandated by the state of Connecticut, which is required for all animals to be examined by a licensed veterinarian at Roxbury Animal Hospital every 12 months. I understand that this relationship is necessary to diagnose, prescribe, and medically treat each patient. I assume all financial responsibility incurred at Roxbury Animal Hospital. This relationship can be terminated at any time by either party.

_____ _____
Signature Date