Veterinary Medical Center

8750 Nesbit Ferry Road Alpharetta, GA 30022
770.998.8450 www.yourvmc.com

Client Information:

Name (Mr. Mrs. Ms.) _____ County _____
(First) (Last)

Address _____
(Street)

(City) (State) (Zip)

Home Phone (____) ____-____ Cell Phone (____) ____-____ Work Phone (____) ____-____

Email _____ How did you hear about VMC? _____

Second Name _____ Second Phone (____) ____-____

Patient Information:

Name _____ Date of Birth (If unknown estimate age) _____

Male/Female Neutered/Spayed Species _____ Breed _____

Color _____ Markings _____

Previous Veterinarian _____ Phone (____) ____-____

Date of Last Exam _____ Known Allergies _____

Medications (Heartworm/Flea Preventatives/Supplements/Etc.) _____

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I hereby grant authority to the Veterinarian(s) in charge of the care of the pet(s) described above to administer any treatment; anesthetics; and/or perform such operations as may be necessary or advisable in the diagnosis and treatment of this/these pet(s). Any animal hospitalized will be required to have current vaccinations and will be given the vaccines prior to admission if not current. I also understand payment is required in full at the time services are rendered.

Signature _____ Date _____