



WELCOME to our practice! For the safety of everyone and their pets, Cats must be in a carrier and Dogs must be controlled on a leash, thank you!
 In order for our records to be as complete as possible, please provide the following:

CLIENT INFORMATION:

Name: _____ Spouse's Name: _____

Primary Phone: _____ Alternate Phone: _____

Address: _____ City: _____ State: _____

Zip _____ Driver's License #: _____ E-mail: _____

How did you hear about our practice? (Circle One)

- Broadcast (TV/Radio/Movies) Customer Review Site (Yelp/City Search etc)
- Friend or Family Member Newspaper/Magazines/Billboard Free Visit certificate
- Sign/Drive-By/Walk-in Website/Online Local Business
- Yellow Pages Buffalo Shelter Facebook or Twitter
- Pet Pals Referral- Whom may we thank for referring you to our practice? _____

PET INFORMATION

Pet's Name: _____ Dog / Cat Breed: _____ Color _____

Sex: Male / Female Neutered: Yes / No Color: _____ Age: _____

Microchip Yes / No _____

Please indicate any current medical problems your pet may have:

Do you have additional health records to provide? Previous Veterinarian: _____

Are you interested in information about our Paw Plans (Wellness Plan)? Yes/No

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.
 TO PREVENT THE SPREAD OF INFECTIOUS DISEASES AND PARASITES IN OUR HOSPITAL, ALL BOARDING AND HOSPITALIZED PETS MUST BE CURRENT ON VACCINES AND FREE OF INTERNAL AND EXTERNAL PARASITES.
 I authorize the doctor(s) to provide vaccines and parasite control as needed for my pet.
 I hereby authorize the performance of accepted diagnostic, therapeutic, and/or surgical procedures. I accept financial responsibility for these services. *We will gladly prepare a written treatment plan for any services being performed if you desire. I am the owner of the above animal or have authority to consent to its treatment.

_____/_____/____ Date
 Signature (Owner or Agent)

Buffalo Small Animal Hospital



Photo/Testimonial Release Form

Owner's name _____

Address _____

Phone number _____

Email Address _____

Pet name _____ DOB _____ Breed _____

I give Buffalo Small Animal Hospital the right to use my testimonial (or photo) provided for reproduction in any medium including but not limited to: website, video, broadcast, print, and electronic means for purposes of advertising, trade, display, exhibition, or editorial use. Further, I also agree to release Buffalo Small Animal Hospital from all claims for libel, slander, invasion of privacy, infringement of copyright or right of publicity or any other claim and I confirm that I am over 18 years of age.

(owners personal information will not be included unless requested by the owner).

Signature _____ **Date** _____



Buffalo Small
Animal Hospital

PAYMENT

All Payments are due at the time services are provided.

We accept Cash, Visa, MasterCard, Discover and Care Credit.

We also accept personal checks (returned check fee for insufficient funds \$40). Payments should be made payable to: Buffalo Small Animal Hospital.

In the event that a client has an outstanding balance, we will send statement(s) requesting payment. A \$4 Statement fee will be added to the balance as a processing/ late fee. Late fees will continue to accrue until balance is paid in full.

If an account goes into default, additional fees will be incurred. If the account is placed with a collections agency, the client will be held responsible for any fees associated with collecting that debt. Once in default, Buffalo Small Animal Hospital will take all necessary means to collect the amount owed.

I understand and agree that if I default on my balance owed, Buffalo Small Animal Hospital may disclose the fact that I have defaulted and other relevant information to the credit bureau organizations. I understand I will be responsible for all fees incurred for collections.

Print Name _____ Phone # _____

Signature _____ Date _____

PATIENT RELEASE OF MEDICAL RECORDS FORM

Date: ___/___/___

Owner Name: _____

Owner Address: _____

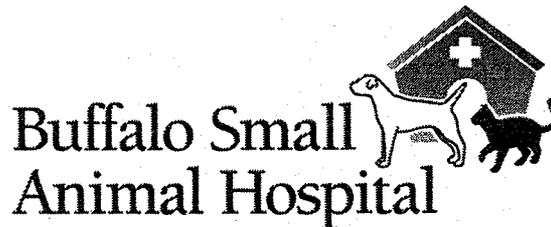
Pet Name(s): _____

Breed: _____

Sex: M / F Age: _____

I, _____, the owner or authorized agent for the above mentioned pet(s), request and give my permission to release the medical records including any images for my pet from the following veterinary hospital:

Please forward a copy of my pet's records to:



243 South Elmwood Ave

Buffalo, NY 14201

Phone: 716-852-1112

Fax: 716-853-0137

Email: Buffaloesmallanimal@nvanet.com

Printed Owner Name: _____

Signature of Owner or Owner's Agent:
