



CHESAPEAKE VETERINARY SURGICAL SPECIALISTS

Client Information This is my first visit to CVSS I have brought other pets to CVSS Date _____

Last Name _____ First _____

Co-Owner Last Name _____ Co-Owner First _____

Address _____ City, State, Zip _____

Home Phone (____) _____ Work Phone (____) _____

Contact Numbers: Cell (____) _____ E-mail _____

SSN: (optional) _____ - _____ - _____ Driver's License _____ State _____

Patient Information

Pet's Name _____ Species: Dog Cat Other _____

Breed _____ Color _____ DOB / Age _____

Sex: Male Female Neutered Spayed Weight _____

Number of **Other** Pets in Household: Dogs _____ Cats _____ Other _____

Obtained From: Pet Store Humane Society Breeder Other _____

You have your pet primarily for: Show Work Breeding Companionship Other _____

Your Pet is: Indoors/Outdoors Only Indoors Only Outdoors

When outdoors your pet is: Loose Fenced Leashed Other _____

Has your pet ever been outside the state of MD? Yes No If Yes, where? _____ When? _____

Your Pet's usual diet is: _____ Canned Dry

Referring Veterinarian

Doctor's Name _____

Hospital Name _____

Address _____ City, State, Zip _____

Office Phone (____) _____ Fax Number (____) _____

It is important for your regular veterinarian to be kept informed about the treatment performed at this hospital. Your signature authorizes Chesapeake Veterinary Surgical Specialists (CVSS) to release a copy of your pet's medical record for your veterinarian's file.

Fees for all services are due and payable prior to your pet's discharge from the hospital. The low end of the estimate is required as a deposit for most procedures. We accept cash, check and most major credit cards. **CVSS does not provide payment plans.**

I, the undersigned, assume financial responsibility for all charges incurred, and agree to pay all such charges at the time services are rendered.

Authorizing Signature